

Conceptualisation of mental illness among Christian clergy in Harare, Zimbabwe

By

Ignicious Murambidzi

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Supervisor

Associate Professor Sharon Kleintjes

Department of Psychiatry

University of Cape Town, South Africa

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ABSTRACT

Background: More than 13% of the global burden of disease is estimated to be due to neuropsychiatric disorders, with over 70% of this burden in low- and middle-income countries. Characterised by severe shortages of human and material resources, formal mental health services alone are inadequate to meet the burden of mental disorders in low- and middle-income countries. New community models and innovative ways of increasing community participation and systematic delegation of specific tasks to other community level professionals have been recommended. Available evidence documents historic clergy involvement in health and wellbeing issues, but they have rarely been viewed as a partner in community mental health care.

Aim: This study examines the clergy's conception, recognition of and responses to people with mental illnesses. The purpose of the study is to inform the potential roles and contributions of the clergy to community mental health either as the only contact or as a step in to formal mental health care.

Method: Twenty eight in-depth interviews were conducted with clergy from ten church denominations in Harare, Zimbabwe. A framework analysis approach was used for thematic analysis. Nvivo 10 qualitative data software was used to organise the data.

Results: Mental illness was conceived as a multifactor phenomenon attributed to both natural (biological and psychosocial) and supernatural (malevolent and benevolent spiritual) causes. Spiritual factors were a dominant theme in both the clergy's views on the causes of, and in their management of mental illness. The clergy were regularly consulted on a variety of emotional and psychological problems. Assistance was readily provided for these problems by all denominations, despite professed capacity gaps in the recognition and management of mental illness, and lack of appropriate training in basic mental health issues. Basic mental health training was recommended by the clergy to enhance clergy capacity for mental health awareness raising, recognition of mental disorders, brief problem focused counseling, and for improving collaborative management for initial and continued informal and formal health care and support. Implications of clergy conceptions, current responses and the perceived role of the church in community mental health are discussed.

Key words

Clergy, religion, spirituality, explanatory models, mental illness, mental health

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DEDICATIONS

To my beloved wife, Sheillah.

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CHAPTER1. INTRODUCTION

1.0 Introduction

More than 13% of the global burden of disease is estimated to be due to neuropsychiatric disorders, with over 70% of this burden in low- and middle-income countries (Tomlinson & Lund, 2012). Formal mental health services are inadequate to address this burden. It is estimated that one out of four people in Africa may experience common mental disorders in a given year (Monteiro, 2015), while more than 75% of people with severe mental illness in low-income countries do not receive the mental health services they need (Mendenhall et al., 2014; Funk & Ivbijaro, 2008; Kohn et al., 2004). Shortage of a trained mental health workforce has been reported as one of the major reasons for the disproportionate and huge mental health treatment gap (Kakuma, Minas, van Ginneken et al., 2011; Saraceno, van Ommeren, Batniji, et al., 2007; Saxena, Thornicroft, Knapp & Whiteford, 2007). The World Health Organisations (WHO) Mental Health Atlas (2014, 2011) reported an estimated rate of 0.05 per 100 000 population for psychiatrists and an estimated overall shortage of mental health workers of 17.3 per 100 000 population in low-income countries.

Zimbabwe, like many other low-income countries has an overwhelming shortage of mental health workers and a huge mental health treatment gap. The WHO (2011) estimated that there were 0.06 per 100 000 psychiatrist, 0.04 per 100 000 psychologists, and 2.86 per 100 000 nurses in the country. The long-standing shortage of health care professionals has been further compounded by the massive emigration of medical professionals from Zimbabwe during the past two decades (Nepachem, 2010). Chikanda (2006) reported that the country has lost an average of 20% of its health care professionals to emigration every year. For instance, data showed that in 2002, the United Kingdom alone issued 2,346 work permits to nurses from Zimbabwe (Chikanda, 2005). Thus, the severe shortage of mental health professionals has undoubtedly

contributed to a critical shortage of mental health personnel and the prevailing huge mental health treatment gap.

Literature reports an urgent need to strengthen and expand the mental health workforce to ensure that effective and affordable treatment reaches the vast majority of people who live in low resource settings (WHO, 2013, 2011; Kakuma, et al., 2011; Lancet Global Mental Health Group, 2007). The WHO (2007) recommended task shifting as one of the methods for strengthening and expanding the health workforce to meet the rapidly increasing demand for health care services. In support, the Lancet Global Mental Health Group (2007) underscored the need for research priorities to focus on the development and evaluation of interventions that can be delivered by people who are not mental health professionals, as the concept had not been widely applied and evaluated with respect to mental health care in low-income countries.

There is evidence suggesting the effectiveness of providing mental health care through non-mental health professionals following brief training and appropriate supervision by a mental health specialist. Kakuma et al. (2011) reviewed the state of mental health human resources in low- and middle-income countries and reported that mental health care can be delivered effectively in primary care settings, through community-based programmes and task shifting approaches that engage and support skilled non-specialist health professionals, lay workers, affected individuals, and caregivers in mental health service delivery. In Zimbabwe, Chibanda et al. (2011) reported clinical improvements in common mental disorders among a population with a high prevalence of people living with HIV following problem-solving therapy delivered by lay health workers.

Further, health care systems in low and middle-income countries are pluralistic, that is, the biomedical health care systems coexist with alternative treatment methods also known as traditional and complementary medicines (Gureje et al., 2015; WHO, 2013; Campbell-Hall, et al., 2010; Patel, et al., 1995). Whilst in most cases biomedical care is the dominant player, the growing demand and widespread use of traditional medicine among people with chronic illnesses has also been documented (Gureje et al., 2015; Abdullahi, 2011; WHO, 2002). Gureje, et al. (2015) reported that depending on the methods employed and the disorders examined, the use of

traditional medicine vary between 20-80% among psychiatric patients. Ayorinde, Gureje & Rahman, (2004) reported that nearly 70% of mental health services in Nigeria were delivered through traditional medicine practices such as religious organisations and traditional healers. Kar (2008) reported that 85.5% of psychiatric inpatients in Orissa, India, believed in supernatural causation of mental illness and 75% of the patients had attended faith healing before seeking medical help.

There is evidence from both high and low-income countries regarding the regularity of contact and influence that the clergy have with people experiencing emotional and mental health problems. In high income countries, clergy's position as personal counsellors, advisors, and mental health gatekeepers has been widely reported (Lukachko, Myer, & Hankerson, 2015; Sullivan, et al., 2014; Watson & Hayter, 2011; Weaver, 1995). Although very few studies focus exclusively on the role of the clergy in mental health in low-income countries, data indicate an increasing trend of psychiatric clients consulting the clergy and spiritual churches ahead of other traditional therapies, such as traditional healers, shrines and herbalists, due to the changing cultural and religious beliefs and the incorporation of some aspects of spiritual therapies such as chaplaincy services into the formal health care system (Atindanbila & Thompson, 2011; Sorsdahl et al., 2009; Adewuya & Makanjuola, 2009; Osei, 1994).

Notwithstanding the reportedly regular consultation of the clergy by people experiencing emotional and mental health problems and the clergy's long historical involvement in healing and healthcare, the clergy is rarely viewed by mental health professionals as a partner in mental health care (Wood et al., 2011; Payne, 2009; Leavey, Loewenthal & King, 2007; Weaver, 1995). The non-recognition of the clergy's contribution to mental health care has been attributed to many historic factors which include ideological conflict, disparate goals and the general mistrust which characterised the clergy-mental health relationship (Sullivan, et al., 2014; Leavey, Dura-Vila, & King, 2012; Oppenheimer, Kevin, Flannelly & Weaver, 2004). However, recent studies indicate an increased understanding of the intersection of religion, spirituality and mental health and the need for mutual collaboration between religious leaders and mental health professionals (Ramakrishnan, Rane, Dias, et al., 2014; Sullivan, et al., 2014; Koenig, Zaben, & Khalifa, 2012).

There is evidence to indicate that religion may be a great resource to people experiencing both physical and psychological distress as it may help the individual to cope with the stress of their illness, promote recovery, influence help-seeking and compliance with treatment (Koenig et al., 2012; Leavey, 2010; Bhui & Bhugra, 2002; McCabe & Priebe, 2004). Further, it has been noted that the clergy may be the first and only professional that individuals may consult on mental health issues (Lukachko, et al., 2015; Wood et al., 2011; Leavey, 2010; Moreira-Almeida & Koenig, 2006).

Studies have also shown that clergy beliefs may influence congregants' use of formal mental health care (Sullivan, et al., 2014; Matthews 2007; Young, Griffith & Williams, 2003). Sullivan, et al. (2014) noted that the clergy who predominantly view mental illness as rooted in spiritual causes are more likely to endorse religious and spiritual healing and may dissuade members from consulting formal mental health professions. It is therefore important to understand the process by which mental health needs are understood, identified and managed by the church, as such information could inform future research and clinicians on religious factors that either facilitate or hinder the use of formal mental health services. Further research would also provide valuable data on how the church as a community resource could be organized and tapped to promote mental health (Leavey, et al., 2012; Hankerson & Weissman 2012).

Given the close link between spirituality and one's mental wellbeing (Koenig, 2012; 2008; Leavey 2010; 2008) and the medical pluralism in mental health treatment (Teuton, Bentall & Dowrick, 2012; Machinga, 2011; Campbell-Hall et al., 2010; Patel, et al., 1995), data on how the clergy's understanding of mental illness and their subsequent responses to the mental health needs of the congregants is particularly important in determining the feasibility of scaling up mental health services through the use of non-mental health professionals, in particular the clergy.

1.1 Background to Christianity and Mental Health Care in Zimbabwe

Zimbabwe is a land locked country in Sub-Saharan Africa and shares borders with South Africa, Botswana, Zambia and Mozambique. The latest population census conducted in 2012 reported a

total population of 13 061 239 with estimated 67% of the population residing in rural areas (Zimbabwe National Statistics Agency, 2012). After independence in 1980, Zimbabwe had a strong and vibrant economy which however collapsed during the hyperinflationary period which began in the late 1990s (Osika, et al., 2010). According to the World Bank ratings, Zimbabwe is a low-income country with high rates of poverty, that is, more than 72% of the population are categorised as poor with a fifth of the population in extreme poverty (World Bank, 2016). Health, education and other basic services were severely affected and remain delicate following a socio- economic crisis the country experienced from 2000 to 2009 as reflected by the country's Human Development Index (HDI) which stood at 173 out of 187 countries in 2011 (UNDP, 2013; Osika et al., 2010)

1.1.1 Christianity in Zimbabwe

Christianity in Zimbabwe was introduced by missionaries in the nineteen century. The pioneering missionaries to Africa were not only involved in religious activities but also undertook educational and health missions (Haynes, 1996). For example, the modern Catholic church in Zimbabwe has its beginnings in the early 1890s when Father Hartmann accompanied the Pioneer Column to Zimbabwe as Chaplain while and Father Prestage accompanied the Dominican nuns who came as nurses. The health and educational missions undertaken by the Dominicans played a pivotal role in the expansion of the early church in the country (Religion Zimbabwe, 2016.) Today, Christianity is the leading religion in the country with about 84% of the population estimated to be Christians (Zimbabwe National Statistics Agency and ICF International, 2012). It is estimated that the 84% Christian population in Zimbabwe is comprised of the following Christian groupings: 33% Apostolic, 17% Pentecostal, 16% Protestant, 10% Catholic and 8% other Christians. About 1% of Zimbabweans were estimated to be Islamic, 3% practice African traditional religions while 12% are non-religious (Religion Zimbabwe, 2016).

Christian churches in Zimbabwe have diverse beliefs, teachings and practices. In this regard, brief summaries of the four major Christian organizing boards for the various denominations will be provided. Firstly, the Zimbabwe Council of Churches (ZCC) was founded in 1964 as an umbrella body representing more than 25 churches, the majority of which belong to the

‘Protestant body’ (Verstraelen, 1995). According to Ruzivo (2008), the ZCC emerged largely as a result of an inspired African movement to create a forum where Christian leaders from different denominations could tackle matters of mutual concern such as fostering effective ecumenical witnessing, unity among churches, and coordination of denominational activities.

The second church organizing board is the Evangelical Fellowship of Zimbabwe (EFZ). Formed in 1962, the EFZ is a fellowship of churches, church related organisations, and individuals who share a desire to express unity, fellowship and combined action among churches and organisations of evangelical persuasion (Ruzivo, 2008). The EFZ has more than one hundred members, the majority being Pentecostal churches. Common among Pentecostal churches is the belief in experiential faith, the Holy Spirit, spiritual gifts of glossolalia, faith healing and the efficacy of miracles (Haynes 1996).

The Zimbabwe Catholic Bishops’ Conference (ZCBC) was constituted in 1969 as the coordinating board for the Catholic Church’s activities in the country. As one of the early missionary churches in the country, the Roman Catholic Church had been widely engaged in religious, educational, health and socio cultural activities. Roman Catholics in Zimbabwe number over one million and are organized into eight dioceses (Religion Zimbabwe, 2016.).

The Union for the Development of Apostolic Churches and Zionist in Zimbabwe Africa (UDACIZA) is the umbrella organisation of the Apostolic faith-based organisations in Zimbabwe. It is a coalition of over 160 Apostolic churches categorically referred to as African Initiated Churches. According to Haynes (1996), African Initiated Churches has its beginnings in the 1920s when African Christians became increasingly dissatisfied with the Eurocentric approaches of missionary institutions as well as the failure of missionary churches to deal with such issues as sickness, health, fortune and misfortune from an African perspective. Thus, from a religious standpoint, Apostolic Churches regarded themselves as spirit-led churches incorporating elements of indigenous spirituality into their Christian beliefs and practices (Haynes, 1996). According to Maguranyanga (2011), Apostolic churches conceptualise the spiritual realm dichotomously, that is, the benevolent Holy Spirit and malevolent evil spirits.

In Zimbabwe the Christian religion has stamped its dominance over traditional cultural beliefs on health matters (Ganiel, 2010; Gunda, 2007). Early colonial missionary investments in health and education were instrumental in the expansion of Christianity in the country while the rise of African Initiated Churches (AICs) eroded the influence of traditional witchdoctors and diviner-healers by integrating the Shona traditional and cultural beliefs into Christianity (Maguranyanga, 2011; Ganiel, 2010; Gunda, 2007; Zvobgo, 1996). Anderson, cited by Gunda (2007, p.241) noted that “in many AICs in Southern Africa, the prophet healer has taken over the function of the traditional diviner-healers”. More recently, the Pentecostal churches in Zimbabwe further weakened the role of traditional witch doctors and diviner-healers by claiming supremacy over pertinent socio- economic and religious issues which people may face in their daily lives (Ganiel, 2010; Gunda, 2007). Evidence from other African countries further indicate an increasing preference and consultation of the clergy and spiritual churches on mental health issues ahead of indigenous traditional therapies and formal biomedical care (Atindanbila & Thompson, 2011; Adewuya & Makanjuola, 2009; Osei, 1994).

1.1.2 Mental Health Care in Zimbabwe

Zimbabwe’s health care system has a centralized policy and administrative structure and a decentralized service delivery system. Formal health care is provided by public facilities, private individuals and companies, non-profit voluntary organisations, and church organisations. After independence, the government adopted the Primary Health Care Approach which saw formal health services being decentralized and established at primary, secondary and tertiary levels of care across the country. Further, the indigenous traditional healing systems which had weathered the colonial storm continued to provide treatment for a variety of illnesses (Osika et al., 2010). Worth noting at this point is that most of the health system gains realized during the first two decades after independence were eroded during the hyperinflationary period which ensued post 2000. In addition, the overall budgetary allocation for health has remained below the Abuja Declaration of 15% of a country’s total budget (Osika et al., 2010).

Mental health services were decentralized in the mid 1980s in line with the primary health care principles. The Department of Mental Health was established within the Ministry of Health in

1981 to spearhead the integration and decentralization of mental health services. Various interventions were initiated which include integration of preventive, promotive, curative and rehabilitative services into general health care, establishment of provincial and district psychiatric units, mental health promotion and education, and mental health training for all service providers. However, due to resource constraints, both human and financial, some of these initiatives were abandoned before completion (Mangezi & Chibanda, 2010). For instance, while each of the provincial hospitals was supposed to have a psychiatric unit, only four out of the nine provinces have such units. Currently the country has nine civilian mental health institutions with a total of 1 212 psychiatric beds in the country's four referral institutions (Pitorak, Duffy & Sharer, 2012). In addition, there are also some psychiatric beds in provincial psychiatric units, two special forensic psychiatric institutions and eleven community facilities, that is, halfway homes and rehabilitation centers (Pitorak, Duffy & Sharer, 2012).

Mental health services in Zimbabwe are provided for and regulated by the Mental Health Act (1996), Mental Health Regulations (1999), Mental Health Policy (2004), and the recently launched Zimbabwe National Strategic Plan for Mental Health Services 2014-2018. Emphasis is on multidisciplinary management of mental illnesses at primary care. The Traditional Medical Practitioners Council Act (1981) provides for and regulates the practice of traditional medical practitioners who, under this Act, are licensed to identify, diagnose and treat physical and mental illnesses using traditional methods. Over and above, there are also provisions relating to mental health in other laws and policy documents, which include general health, disability, education and welfare. For example, the National Community and Home Based Care Strategic Plan 2010-2015 (C&HBC) outlines the framework and strategies for community prevention, treatment, care and psychosocial support for children and adults with terminal and chronic illnesses such as HIV and AIDS, tuberculosis, cancer, diabetes, hypertension, epilepsy and mental illness. Notwithstanding the existence of such progressive legal provisions concerning mental health care in the country, implementation has been patchy while prevention, treatment and care services have largely remained institutional, underdeveloped, and inadequate (Mlambo et al, 2014; Pitorak, Duffy & Sharer, 2012; Mangezi & Chibanda, 2010).

In Zimbabwe, both formal and informal mental health services are respectively presided over by the Minister of Health and Child Care through the Department of Mental Health and the Department of Traditional Medicine. Formal health workers at primary care level have the authority and training to diagnose and treat mentally ill persons and refer only those that they feel require specialized services. A number of officially approved manuals and guidelines on the assessment, treatment and referral procedures exist at both primary and secondary care levels (WHO Atlas, 2011). Informal mental health care is provided by traditional healers, prophets, faith healers and spirit mediums registered with the Zimbabwe Traditional Medical Practitioners' Association. However, Zimbabwean clergy involved in spiritual healing practices remain unregistered on the pretext that they cannot be classified in the same bracket with traditional healers and spirit mediums (Religion Zimbabwe, 2016).

The pathway to care for Zimbabweans experiencing mental illness typically begin with consulting traditional healers, prophets and faith healers before accessing the formal health care system (Duffy et al., 2015; Muchinako, Mabvurira & Chinyenze, 2013; Shizha & Charema, 2011). After the initial consultation and treatment by a traditional medicine practitioner, the client may seek formal mental health care either upon advise from the traditional practitioner who believes that the aetiology has a physiologically base or as a result of being dissatisfied with the non- responsiveness of the prescribed traditional treatment. Thus, there is an informal and unregulated referral system between the traditional medicine practitioners and formal mental health care providers. Despite the attempts made by the Zimbabwe National Traditional Healers Association (ZINATHA) to educate its members on the referral procedures for patients with mental health problems to the formal sector, there has not been much collaboration between the formal and informal mental health service providers (Mangezi & Chibanda 2010).

Zimbabwe, like other low-income countries, has high prevalence rates for common mental disorders. Official estimates by the Ministry of Health and Child Care in 2015 indicated that approximately 1.3 million Zimbabwean suffer from mental illness while about 7 763 new cases of mentally ill persons were recorded in the country's hospitals from January to October 2014 (Daily News, 2015). Epidemiological studies have also posted high prevalence rates of mental disorders, for example, 67.9% and 68.5 % for depression and anxiety disorders respectively

among people living with HIV (Chibanda et al., 2016); 51.7% risk of affective disorders, 23.8% severe affective disorders and 10.1% of suicidal ideation among adolescents living in rural Zimbabwe (Langhaug et al., 2012). Furthermore, prevalence rates for other mental health disorders were 59.9% for alcohol use or abuse among first year university students (Nkoma, & Bhumure, 2014); 33% for depression among postpartum women attending postnatal visits at two urban primary care clinics (Chibanda et al., 2010), while 71.3% of the subjects who tested HIV sero-positive in an urban cross-sectional study met DSM IV criteria for schizophrenia, depression, mania, generalized anxiety disorders and other psychiatric disorders (Sebit et al., 2003). With regard to psychiatric hospital admissions, Mangezi and Chibanda (2013) noted that in-patients in Zimbabwe typically present with schizophrenia, substance-induced psychosis, bipolar affective disorder (mania), epilepsy or the psychiatric complications of HIV. The WHO Mental Health Atlas (2011) estimated that neuropsychiatric disorders contribute about 3.1% of the global burden of disease in the country (WHO, 2011).

1.2 Problem Statement

Zimbabwe, like many African countries, has a pluralistic health care system within which citizens visit and consult traditional healers, religious church leaders and formal biomedical health services in hospitals and clinics for health and healing (Monteiro, 2015; Machinga, 2011; Campbell-Hall et al., 2010; Gunda, 2007; Patel et al., 1995). Research evidence indicates that local traditional and religious beliefs and values play a significant role in health and healing practices of the Shona people in Zimbabwe (Basure & Taru, 2014; Maguranyanga, 2011; Gunda, 2007; Patel et al., 1995; Chavhunduka, 1994).

With respect to formal mental health services in Zimbabwe, mental health care has been severely affected by a shortage of human resources. An official report by the Zimbabwe Ministry of Health and Child Welfare, the 2012 National Health Strategy, indicated a 50% vacancy rate for psychiatric nurses while about 90% of the in-post psychiatric nurses were disproportionately situated at one of the country's referral hospitals for mental illness (Ministry of Health and Child Welfare, Zimbabwe, 2012). The WHO Atlas (2011) estimated the number of psychiatrists in the

country to be 0.06 per 100000, psychologists 0.04 per 100 000 and nurses 2.86 per 100 000 population.



Given the critical shortage of mental health care personnel in the country, it is the contention of this study that it would be imperative to embrace recommendations for task shifting approach by engaging non specialist health workers and other community level professionals such a religious leaders to provide specific mental health care and support services (Mendenhall et al., 2014; Kakuma et al., 2011; Lancet Global Mental Health Group, 2007). In the context of the pluralistic Zimbabwean health sector, engagement of the faith-based sector in task-shifting is an evidence-based focus recommended in one of the studies showing preference for religious leaders, faith healers, traditional healers, and other lay people, ahead of non-specialist health workers such as community health workers (Mendenhall et al., 2014). This is particularly relevant given that the Zimbabwe Demographic Health Survey Report (2010-11) estimated that about 84% of the population are Christians, 1% Islamic. 3% practice African Traditional religions while 12% are non-religious (Zimbabwe National Statistics Agency [ZIMSTAT] & ICF International, 2012).

1.3 Purpose of the Study

The current study explores the clergy's conception, identification of and responses to people with mental illnesses. This exploration aims to provide insights from local clergy on the possible roles and contributions of the clergy to the mental health needs of their congregants and the community at large, either as the only contact or as a step towards formal mental health care.

This research therefore seeks to contribute towards the knowledge base of religion and mental health and further explore opportunities for scaling up community mental health care through collaborative engagement of the clergy. More specifically, this study will address the following research question: What is the clergy's understanding of and response to mental illness?

This will be explored in more depth through the following sub-questions:

-  What causes and meanings do the clergy ascribe to mental illness?
-  What are the clergy's perceptions on the church's role and contribution to addressing mental health problems among their community members?

- ✚ How do the clergy's beliefs and perceptions impact on their recognition and management of persons with mental health problems?

Objectives

The study addresses the following specific objectives:

- To document the predominant beliefs and explanations for mental illness among the Christian clergy in Zimbabwe.
- To document the clergy's perceived role and contribution to community mental health.
- To explore the influence of clergy's beliefs and perceptions of their recognition and management of mental health problems.

CHAPTER 2 LITERATURE REVIEW

2.1 Introduction

This chapter reviews literature on the clergy's conceptualization, recognition and response to the mental health needs of their congregants and community members at large. The review was conducted to appraise the existing knowledge regarding the focus of the current study, to identify gaps in the current literature, potential strategies and solutions to dilemmas, and to contextualize the focus of this study as a potential contribution to generating new evidence on religion and mental health.

The literature search was conducted on electronic databases and hand searching of journal articles relating to the topic of clergy's conceptualisation of and response to mental illness. The search was not restricted by date, and publications from low, middle and high income countries were included. The electronic database search was conducted on Medline, Psych Info, and Cochrane using the following medical subject heading (MeSH) search terms: concept* OR percept* AND mental illness OR mental health OR mental disorders AND clergy OR religious leader. Other key words used were spirituality, religion, and explanatory model. Reference lists for the selected papers were also screened to identify additional relevant studies. In addition, specific journals which were frequently referenced in the papers were hand searched such as Transcultural Psychiatry, Mental Health Religion and Culture, Central African Journal of Medicine, British Journal of Psychiatry, Lancet and Community Mental Health Journal which were available in the Health Sciences Library at the University of Cape Town and the University of Zimbabwe library.

The search yielded 2377 abstracts which were reviewed by the researcher to determine if the content related to clergy conceptualisation of and responses to mental illness. Duplicates and abstracts which did not meet the inclusion criterion, for example, articles detailing the treatment models such as traditional healing process, faith healing and pastoral counselling were removed.

The remaining 78 relevant full text articles were read to extract and list key issues and themes pertinent to the study as informed by the research questions. These include:

- Explanatory models of mental illness, more specifically clergy's conceptualisation of mental illness (33 articles);
- Clergy recognition and response to the mental health needs of their congregants and the perceived role and contribution of the church to community mental health (26 articles);
- Mental Health gaps and potential strategies to improve community mental health through innovative and cost effective community interventions (19 articles).

2.2 Explanatory Models of Mental Illness

The term 'explanatory models' coined by Kleinman (1973) describes explanations of episodes of illness and treatment that are framed within the context of cultural beliefs and norms of the given society and permeates all aspects of interaction between the healer and patient. Aidoo and Harpham (2001) noted that explanatory models have been used more widely to explain meanings of illness within mental health as compared to any other field of health studies. The importance of the socio-cultural meanings of illness is also acknowledged in the latest version of Diagnostic and Statistical Manual of Mental Disorders (DSM –5), in its emphasis on cultural formulation of mental disorders (American Psychiatric Association, 2013).

Explanatory models have been used to delineate concepts, categories, causes, and treatment of common mental disorders. Research studies that examined explanatory models have reported both cultural and individual variations in the explanations relating to the presentation, identification, perceived causes and treatment for mental distress (Khoury et al., 2012; Aina & Morakinyo, 2011, Bhui et al., 2006; Shankar et al., 2006; Patel, 1995. They have also reported substantial differences in explanatory models between patients and professionals resulting in some disharmony and problems in the diagnosis and treatment of common mental disorders in culturally diverse societies (Aina & Morakinyo, 2011; Kleinman et al., 2006, Aidoo & Harpham, 2001).

Studies on conceptualization of mental illness show three streams regarding the interrelationship between culture and mental illness (Kleinman et al., 2006; Patel, 1995). Firstly, occidental studies assuming the etic approach argue that the basic psychopathology of all mental disorders is universal. Drawing from the biomedical model, the etic perspective assumes that mental illness has similar epidemiology and as such, health care packages designed in high income countries are also applicable to low-income countries. The second research stream adopted the emic, cultural relativistic approach advocating for the assessment and understanding of mental illness from the perspective of the local culture and the context in which it's being experienced. For instance, Ventevogel et al., (2013) noted that local communities in Burundi, South Sudan and the Democratic Republic of the Congo had a range of culturally inclined taxonomies of mental illness which were not identical to mainstream psychiatric categories. The third stream, common with cross-cultural research, has attempted to bridge the etic and emic approaches with evidence supporting dimensional and integrative approaches which locate mental illness in a continuum along the previously dichotomous etic-emic viewpoints (American Psychiatric Association, 2013; Khoury et al., 2012). This perspective is in keeping with the growing evidence suggesting the integration and collaboration of conventional biomedicine and traditional and complementary systems of medicine (Gureje et al., 2015; WHO, 2013; Aina & Morakinyo, 2011)

In Africa, as in many other low-income countries, concepts of mental health and illness are influenced by the African world view of health and diseases (Gureje et al., 2015; Shizha & Charema, 2011; Waldron, 2010; Omonzejele, 2008). According to Omonzejele (2008), the African concept of health is based on the African unitary view of reality which is usually understood in terms of one's relationship with his or her ancestors. In this regard, health is not just about the proper functioning of bodily organs, but encompasses aspects of spiritual harmony with ancestors as it is believed that for one to enjoy robust health, ancestors must be honoured so that they continue to perform their ancestral functions, which are principally the protection and welfare of the living. Similarly, the African concept of disease transcends mere organic and tissue malfunctions to include superhuman forces, ancestors, witches, spirits, and gods. Further, diseases are believed to stem from natural, social and psycho-spiritual factors, hence, the healing process does not only target the diseased individual, but is applied holistically to include a

patient's family, relatives and even the entire community (Shizha & Charema, 2011). More importantly, even the seemingly natural causes may not be seen as natural at all but manipulations of spirits and gods, that is, clandestine operations of malevolent spirits to expose, subject or even facilitate one's physical harm and illness (Machinga, 2011; Read, Adiibokah, & Nyame, 2009; Teuton et al., 2007).

The central role of spiritual factors in African concepts of disease and health is further noted in the diagnosis and treatment methods employed, which rely heavily on spiritual acts of divination, incantation, rituals and sacrifices (Gureje, et al., 2015; Madzhie, Mashamba, & Takalani, 2014; Mbwaiyo et al., 2013). Since aspects of spiritual disequilibrium have to be addressed first before physical health issues, psychosocial-spiritual harmony and atonement play significant roles in African health and healthcare (Shizha & Charema, 2011; Omonzejele, 2008). Gureje et al., (2015) noted that in LMIC the notion of spiritual causation of mental illness was upheld by people from all walks of life and "neither urbanization or level of education has affected the common belief in the supernatural causation of mental illness with educated elites consulting traditional healers at a similar frequency to those with no formal education" (Gureje et al., 2015, P.7). Thus, it is still common among both urban and traditional communities in Africa to offer regular sacrifices to their ancestors and deities asking them to protect and bestow good health to the family members (Gureje, et al., 2015; Sorsdahl et al., 2009; Omonzejele, 2008; Teuton et al., 2007).

In Africa, mental illness, popularly known as 'madness,' is often perceived as a multifactorial phenomenon rooted in superhuman forces (Ventevogel et al., 2013; Abbo 2011; Sorsdahl et al., 2010; Teuton et al., 2007). A review of studies from eleven Sub-Saharan African countries on beliefs relating to mental illness conducted by Patel (1995) indicated that supernatural factors relating to religious, astrological, magical, and ancestral spirits and gods were reported as frequent causes for mental illness across the region. According to Teuton et al., (2007) there are multiple ways through which spiritual forces could cause mental illness. For instance madness could be a result of spiritual disharmony (which may include angered ancestral spirit and spiritual possession), which is located and influenced entirely from the spiritual realm and usually manifest in the form of communication from the family ancestral spirits. On the other

hand, madness due to social disharmony (which may include witchcraft and sorcery) would be located between the living and spiritual worlds and usually manifest as a mechanism of social control. There is evidence suggesting the traditional and religious healers readily recognise these forms of madness and accordingly advised the required treatment (Gureje et al., 2015; Shizha & Charema, 2011; Read, Adiibokah, & Nyame, 2009; Ally & Laher, 2008).

Besides the above supernatural factors, both indigenous traditional and religious healers acknowledged a range of physical, social and psychological explanations of mental illness. Teuton et al., (2007) noted that indigenous and religious healers in Uganda attributed 'kizungu madness' to such factors as fever, HIV/AIDS, inheritance, substance misuse and poor feeding while psychological factors included negative internal reaction to adversity, deliberate acts of manipulation, and collusion with false beliefs. Moral causes of mental illness were reported among the rural community of Kintampo in Ghana and treatment included physical restraints, chaining and other forms of harsh treatment such as beatings (Read, Adiibokah & Nyame, 2009). Poverty, family problems, substance abuse, conflict and disturbed social relationship were reported in separate studies in South Africa and Uganda (Sorsdahl et al., 2010; Abbo, 2011). Studies in Zimbabwe have reported among other, biomedical and psychosocial factors, physical trauma to the head, physical illnesses, old age, stress, grief, worry, poverty, unemployment and marital problems (Nyamukapa et al., 2010; Langhaug, 2010; January & Sodi, 2006; Patel 1995).

A few of the reviewed papers indicate that individual patients and their families often have their own concepts and explanations for mental illness which may differ from those held by convectional clinicians even when the patient and the clinician are from the same community (Gureje et al., 2015; Khoury et al., 2012; Aidoo & Harpham, 2001). An individual's understanding and belief system may change and differ from the mainstream as a result of education, training and exposure to new perspectives. Thus, it's not uncommon for local clinicians to cherish biomedical concepts for mental illness which may be contrary to the predominant socio-cultural explanations for mental illness.

According to Shizha & Charema (2011), disparities in explanatory models of mental illness between biomedical clinicians and mental health users are common in Africa and other low-

income countries where indigenous explanations of illness, disease and the associated healing practices have been castigated as backward, irrational, superstitious and unscientific. Regrettably, these differences create a disconnection between the user and the provider which contributes to pervasive underutilisation of formal mental health services in some low- and middle-income countries (Monteiro, 2015; Gureje et al., 2015; Shizha & Charema, 2011). Gureje et al., (2015) posit that the mental health users in low- and middle-income countries prefer to consult traditional and faith healers ahead of formal mental health professional because the former's worldview and philosophies are more appealing to their patients and "this often results in the joint pursuit of an end to the abnormal experience of illness" (Gureje et al., 2015p.7). The above observation concurs with an earlier study by Kar (2008) which reported that about 85.5% of psychiatric inpatients in Orissa, India, believed in supernatural causation of mental illness and 75% of the patients reported to have attended faith healing before seeking medical help.

A disconnection in the conceptualisation of mental illness and the use of formal mental health services was also noted by Aidoo & Harpham (2001) among low-income, urban women groups and local health care practitioners in Zambia. The authors noted that while the women frequently used the term 'problems of the mind', practitioners used 'stress and depression' to define and explain mental problems. Further, the women did not regard problems of the mind (that is, low self-esteem, unhappiness or thoughts of suicide) as indicative of mental illness. The women regarded mental illness as madness and as such they did not seek formal psychiatric services for their problems of the mind as they believed that they were not mental illnesses. They also believed that mental illness was due to supernatural forces, 'mashabe,' fate or power of God and therefore its treatment was considered to be outside the spectrum of biomedical services. The authors concluded that greater awareness of explanatory models could impact on mental health planning and service delivery, for example, through training of mental health professional to take into account patients' explanatory models so as to improve the diagnosis and treatment of mental disorders.

Studies from other low-income countries document explanatory models similar in many respects to African concepts of mental illness (Mbwayo et al. 2013; Sorsdahl et al., 2010; Omonzejele, 2008). Khoury et al., (2012) examined mental illness concepts in rural Haiti. The study revealed

dominant explanations as rooted in the supernatural Vodou explanations which attributed mental illness to spiritual possession. Although the Vodou perspective was reported as central and espoused by the majority of the rural population, the study also revealed that rural Haitians had concurrent multiple explanations for mental illness and as such, consulted both biomedical and traditional practitioners. The study also noted that the Vodou worldview did not obstruct either biomedical help seeking or formal mental health care delivery in rural Haiti.

Shankar et al., (2006) examined explanatory models for common mental disorders among traditional healers and their patients in rural South India. Mental illness was recognized and categorized as illness of 'kataeri' and 'manna kollaru' (madness), 'saivinai' (black magic), 'peay' or 'pizzazu' (spirits of person who were killed). The causes were mainly spiritual, which include evil spirits and witchcraft. However, other physical and psychosocial factors, for example, physical diseases, family problems, and alcoholism were also reported as causing mental illness.

2.3 Clergy Explanations of Mental Illness

There is a paucity of information on the clergy's explanations of mental illness across different socio cultural groups. What is currently known on this subject is based on a handful of studies that were conducted in high income countries and mainly among African American clergymen. These studies generally report the clergy as upholding modern, bio-psychosocial concepts of mental health and attributed mental illness to a variety of biological, psychological, environmental, religious, and spiritual factors (Sullivan et al., 2014; Payne, 2009; Ellison et al., 2006). Leavey (2010) noted that while spiritual beliefs and explanations for mental illness were equally common among the generality of the clergy, this worldview was particularly strong among Pentecostal and African churches.

Stanford & Philpott (2011) surveyed 168 senior pastors within the Baptist General Convention of Texas to ascertain their knowledge and perceptions of mental illness. The results indicate that the pastors reported biological factors (inherited genes and chemical imbalances in the brain) as

most important causes and further asserted biomedical therapy as most effective treatment for mental illness. Varied responses were noted on the contributions of psychosocial and spiritual factors, which, for example, were perceived as more important in major depression and anxiety disorders than in cases of schizophrenia and bipolar affective disorders. Overall, psychological interventions and pastoral counselling were rated as most effective treatment methods for mental illness while spiritual deliverance was not considered an effective approach to mental illness. However, these findings have to be interpreted with caution as the study sample consisted of highly educated, senior pastors of affluent congregations and their reported views can therefore not be generalized to the large and heterogeneous Christian clergy.

Payne (2009) attributed variations in the clergy's perceptions of the etiology of depression to racial and denominational differences. The author examined 204 Protestant pastors in California on their views about the causes of depression. Both race and religious affiliation significantly influenced pastors' perception of depression. For example, Caucasian American pastors viewed depression as a bio-medical condition, while African American pastors regarded depression as a moment of weakness when faced with life problems. With regards to religious affiliation, mainline Protestants viewed depression as caused by medical or biological factors while Pentecostal pastors believed that depression was caused by spiritual or moral problems. Perceptual differences based on religious affiliation were also noted by Leavey (2010, 2008) who noted that mainstream clergy (Anglicans and Catholics) were more inclined to medical and psychosocial models of mental illness while the clergy from Pentecostal and African churches tended to embrace both natural and spiritual models of mental illness. In one of the studies, Pentecostal clergy called for collaboration between secular and religious practitioners because "psychiatrists are unable to detect the presence of the demonic" (Leavey, 2008, p.86)

Studies among minority groups in high income countries for example, an investigation of Korean American Christian clergy (Kim-Goh, 1993), and Vietnamese American Buddhist leaders (Nguyen, Yamada & Dinh, 2012) report a predomination of spiritual factors over other causes of mental illness. Nguyen et al., (2012) explored Vietnamese American Buddhist leaders' assessment and attribution of the causes of mental illness in Southern California. The monks and

nuns reported that they would identify mental illness through the member's outer appearance, that is, being messy or overly adorned, aggressive and violent behaviours, and poor cognitive functioning. Mental illness was attributed to a variety of causes, which include daily stressors, mind-body imbalance, karma, virtuous deeds, and spiritual possession. These factors could either singularly cause or can interact with one another to trigger distress and mental illness. The authors recommended promotion of faith-based mental health outreaches as a strategy for mitigating the mental health treatment gap (Nguyen, et al. 2012).

A handful of studies conducted in low- and middle-income countries reported multiple beliefs and models that were simultaneously held by the clergy to explain mental illness, which included biological, environmental, spiritual, and psychological factors. These include, for instance, Christian clergy in Singapore (Mathews, 2008, 2010), Muslim faith healers in South Africa (Ally & Laher, 2008) and Apostolic faith healers in Zimbabwe (January & Sodi, 2006). One of the major themes permeating studies on religious and faith healers' perception of mental illness in low- and middle-income countries is the belief that while mental illness and emotional problems may have both natural and supernatural causes, they primarily require spiritual solutions. This line of thought resonates with African traditional healers' belief that even the seemingly physical causes of mental illness always have an insidious supernatural undercurrent and thus, require spiritual healing over and above biological treatment (Machinga, 2011; Omonzejele, 2008, Teuton et al., 2007).

In the study among Singapore Christian clergymen, Matthews (2008) reported the endorsement of multiple models which appealed to both spiritual and psychological factors. Religious models were the most common whilst organic models were least reported indicating that the clergy were more inclined towards models that were more congruent to their theological belief system. An earlier study by Matthews (2007) had however reported that some clergy firmly believe that they were adequately bestowed with gifts and skills for the treatment of mental problems. The clergy believed that only their unique skills and not psychological techniques should form the basis for the treatment of people with mental problems (Matthews, 2007). Similarly Sullivan et al., (2014) noted that the clergy with singular spiritual explanations for mental illness, that is, viewing mental illness as purely manifestations of evil spirits, tended to regard biomedical treatment as

both an indication of lack of faith and a hindrance to spiritual healing which is believed to come through faith and prayer. Consequently, adherents of this school of thought would actively discourage congregants with mental health problems from consulting formal health services (Sullivan et al., 2014; Matthews, 2007).

Ally and Laher (2008) reported that the attribution of mental illness to witchcraft and spiritual possession was common among many religions including Islam. In an investigation of South African Muslim faith healers' perceptions of mental illness, Ally & Laher (2008) noted that the causes of mental illness were seen as stemming from either biomedical factors such as traumatic incidences, childhood trauma and chemical imbalances in the brain or from spiritual factors broadly categorized as jaadoo (black magic) and nazr (ill will). Respondents were reportedly aware of the distinction between mental and spiritual illnesses. Although treatment was primarily spiritual, that is based within Islam religious doctrine, the faith healers would also advise and encourage biomedical treatment if the causes were deemed to be natural (Ally & Laher, 2008).

January & Sodi (2006) investigated practices of Apostolic faith healers in mental health care in the town of Marondera, in Zimbabwe. The Apostolic faith healers reported being consulted on various problems including mental illness, physical ailments and social problems, such as bad luck, unemployment and failure to get married. Witchcraft and avenging spirits were cited as the most common causes for illness. However, the healers also reported other causes for mental illness, which include head injuries, hereditary, infections, stress, marital distress, substance abuse and problems at work. Treatment was mainly through prayer, holy water to drink and bathe, exorcism, holy stones, and string band tied around wrists and ankles. The study reported the faith healers as being in favour of some form of collaboration between themselves and the biomedical health practitioners. The perceived benefits for collaboration included getting more referrals from the formal health centre as well as opportunities to access both material resources and health training to enhance their practices (January & Sodi, 2006).

Worth noting at this point is the dearth of literature on the mainstream clergy's understanding and response to mental illness in Sub-Saharan Africa. Further, available data on alternative traditional treatment of mental illnesses in Sub-Saharan Africa were largely gathered from and refer to indigenous traditional healers' practices (Teuton, Bentall, & Dowrick, 2012; Machinga, 2011; Campbell-Hall et al., 2010; Patel, 1996). This trend is however common in low-income countries where religious leaders are categorized together with indigenous traditional healers as practitioners for traditional and complementary medicine (Gurenje et al., 2015; WHO, 2013; Shizha, & Charema, 2011). The WHO defines traditional and complementary medicine practitioners as all those who use local and indigenous knowledge skills and practices to prevent, diagnose, improve or treat physical and mental illness. In Zimbabwe for example, the Department of Traditional Medicine in the Ministry of Health and Child Care is mandated by the Traditional Medical Practitioners Act Chapter 27:14 of 1981 to regulate the activities of the following categories of traditional medical practitioners: faith healers, herbalists, prophets, herbal medicine practitioners, faith healing churches, traditional birth attendants, spirit mediums, African traditional healers, and distributors of African, Eastern and Western herbal medicine and medicine ingredients.

2.4 Religion, Spirituality and Mental Health

Literature on religion and health show a long and wide history of religious institutions' initiatives and involvement in the health and wellbeing of individuals and families (Fagan et al 2012; Koenig, Zaben & Khalifa, 2012; Campbell et al., 2007; Peterson et al., 2002). Hefti (2011) contend that religious activities and beliefs help to enhance emotional adjustment and to maintain hope, purpose and meaning, noting that more than 80% of psychiatric patients use religious and spiritual beliefs and activities to cope with day to day life challenges. Taylor (2000) cited a number of research studies that showed that religious factors impacted on several health initiatives and outcomes including health care screening programmes for drug, alcohol and tobacco use, hypertension programmes, health care service utilisation, positive life satisfaction, self-esteem and other aspects of health and wellbeing. Taylor (2000) further noted that

examining prevailing religious beliefs and practice collectively provides valuable insights into health status, health related behaviours, and health attitudes for the studied populations.

Although religion is the most common way of understanding and accessing spirituality, not all current conceptions of spirituality are linked to religion (Hill, 2000). According to LaPierre, (cited in Hill, 2000) spirituality is a multidimensional construct which incorporates several attributes including a search for meaning in life, an encounter with transcendence, a sense of community, search for ultimate truth or highest values, a respect and appreciation of the mystery of creation, and personal transformation. In the African cosmological context, spirituality relates to supernatural influences of gods, ancestral spirits, and other superhuman forces believed to have positive and negative influences on every aspect of human line including health, diseases and illnesses (Shizha, & Charema, 2011). Incorporating spirituality issues in health is increasingly acknowledged as important for an integrated view of health, diseases and illnesses, that is, a shift from the mechanistic model to more holistic approach of seeing the self as the sum total of an existing and evolving being with an intimate and interweaved mind, body and spirit (Leavey, 2010; Koenig, 2008; Bhui et al., 2002). The World Health Organisation (1998), for instance, noted that the biomedical model's symptomatic approach seeks to treat patients by focusing on medicines and surgery, whilst paying less attention to the individual's belief system. On the other hand, traditional and complementary medicine has been reported as holistic, that is, incorporating cultural and contextual factors when attending to the physical, social, psychological and spiritual needs of the individual (Gurenje et al., 2015)

According to Hill (2000), religion and spirituality have important psychological and social factors that may serve as either a powerful resource for healing and wellbeing, or a precursor for psychopathology and a barrier for treatment. On the positive side, spirituality is increasingly being recognised as having many protective effects for overall health and mental wellbeing (Koenig, Zaben, & Khalifa, 2012; Hefti, 2011; Moreira-Almeida, et al., 2006). Thus the historic view of patients' spiritual and religious beliefs and practices as having a pathological basis has been challenged by emerging evidence on the mental health benefits of spirituality (Leavey, 2008; 2010; Koenig, 2008). Recent research has uncovered findings which link spirituality to positive coping and wellbeing (Koenig, et al., 2012; Hefti, 2011). Other studies indicate that

religious and spiritual beliefs may influence help-seeking and compliance with treatment (Leavey 2010; Bhui et al., 2002; McCabe & Priebe, 2004). In this regard, Koenig (2008) contends that spiritual and religious beliefs and activities deemed important by the patient should be explored, for instance, the role spirituality and or religion in the patient's coping with present life problems as well as the effect of the patient's membership to a religious group with regard to support or discouragement of formal mental health treatment. Acknowledging the importance of spirituality in mental health, Powell (2002) noted that clinicians' awareness and sensitivity to patients' spiritual needs should be the cornerstone for formal mental health treatment and care.

2.5 Use of Clergy for Mental Health Problems

Literature mainly from the United States of America (USA) and United Kingdom (UK) report regular clergy consultation on a range of emotional and psychological problems. Clergy consultations on mental health related issues was largely reported as consistent with their ministerial and religious roles and training on such matters as bereavement, health, marital and personal problems (Wood et al., 2011; Wang, Berglund, & Kessler, 2003; Taylor, et al., 2000;). Studies from the USA, for example, acknowledge that community based clergy have significant contact with people who suffer from mental health problems, many of whom reported a preference for the help of the clergy ahead of mental health professionals (Hankerson & Weissman, 2012; Farrell & Goebert, 2008). Wang, et al. (2003) reported that in a National co-morbidity survey in the United States, a quarter of those who ever sought treatment for mental disorders did so from a clergy member. This was significantly higher than proportional consultations for psychiatrist (16.7%) and general medical doctors (22.9%), respectively (Wang, et al., 2003).

Similarly, studies in low- and middle-income countries report higher preference and consultation among traditional medicine practitioners on mental health problems. Ayorinde, Gureje & Rahman (2004), for example, reported that nearly 70% of mental health services in Nigeria were delivered through traditional medicine practitioners such as faith healers, spiritual healers and traditional healers. In another study on the public's preferred treatment for mental illness in South Western Nigeria, 41% endorsed spiritual healers, 30% traditional healers and 29% hospital

and western medical care (Adewuya & Makanjuola, 2009). In a comparative study on common mental disorders among those attending primary healthcare clinics and traditional healers in urban Tanzania, Ngoma, Prince & Mann (2003) reported a 48% prevalence of common mental disorders among those presenting at traditional healers, which double the 24% prevalence among those presenting at Primary Health Care centres. Similarly, a study by Kar (2008) reported that about 85.5% of psychiatric inpatients in Orissa, India, believed in supernatural causation of mental illness and 75% of the patients had attended faith healing before seeking medical help. Gureje, et al., (2015) concluded that the high patronage of traditional and faith healers could be related to the compatibility of their worldview, philosophy and the relative ease of accessibility and availability to their clients.

A number of factors have been linked to increased consultation and use of church leaders for personal mental health problems. Taylor et al. (2000) reported that among some of the factors that gave the clergy an attractive and comparative advantage over formal mental health services were absence of user fees among the clergy, higher accessibility and availability of clergy, absence of cumbersome protocols, that is, no formal referrals, long waiting periods, and in some cases the clergy proactively offered their services by conducting personal home visits. In addition, Payne (2009) noted that the clergy are involved in many intimate individual and family lifespan matters, for instance, through various ceremonies conducted at birth, marriage, death and other significant life events. Accordingly, people consult the clergy for help in general life crises, emotional and mental health problems, not because they are unaware of formal mental health care resources, but because they feel close to and comfortable with clergy (Payne, 2009).

Research evidence has shown that clients' preferred treatment and the subsequent care pathways for mental illness are diverse and are dependent on socio cultural and economic factors (Adewuya & Makanjuola, 2009; Campbell-Hall, 2010; Patel, 1996). Abiodun (1995) for instance, noted that the patient's social support system, that is, family members, relatives, and significant others, often play very important roles in determining the type of practitioner patients consult when they become mentally ill. Bhui and Bhugra (2002) regarded the widely varying pathways to mental health care across various societies as a reflection of the many sociocultural and economic factors unique to both the consulting individual and the organisation of the health

care system. Thus, for a patient to reach a formal mental health specialist, he or she would have gone through a series of filters (Bhui & Bhugra, 2002).

Religious leaders in both high and low-income countries have been reported to encounter clients who were categorically similar to clients seen by mental health professionals with respect to both the type and severity of psychiatric problems they presented with. In high income countries for example, the clergy were reported to be widely consulted on mental and emotional problems, marital violence and bereavement (Leavey, 2008; Leavey et al., 2007; Farrell & Geobert, 2008; Taylor et al., 2000). Among low-income countries, January & Sodi (2006) reported that faith healers in Zimbabwe were consulted on a number of psychosocial problems which included mental disorders, social problems, substance abuse disorders, sleep and physical disorders. Campbell-Hall (2010) reported a study by Peltzer, Mngqundaniso & Petros (2006) in which mental health problems were ranked 14th on a list of the most common conditions seen by traditional practitioners in South Africa, affecting 9% of their clients. They concluded that religious healers parallel mental health specialists in the many respects with regards the mental health problems of clients who sought their care.

2.6 Collaboration between the Clergy and Mental Health Professionals

Reviewed studies report minimal collaboration between the clergy and formal mental health professionals (Oppenheimer, Flannelly & Weaver, 2004; Weaver et al., 2003). This is however against available evidence on the mutual benefits of collaboration between the clergy and mental health professionals, which include increased referrals, utilisation of formal health services, treatment adherence and enhanced treatment outcomes for mental health problems as well as the reduction of stigma of mental illness (Leavey et al., 2012; Farrell & Geobert, 2008; Koenig, 2008). Notwithstanding the available evidence on the mutual benefits for collaboration (to both the clergy and mental health professionals) it has been noted that there is need to further articulate and refine the nature of collaboration as religion spans a vast spectrum of beliefs and practices, many of which might not be compatible with formal mental health systems. Specifically there is need for more information on the common interests and the perceived role each sector would play in collaborative management of mental illness so as to dispel latent

suspicion and conflict between the two sectors and open the much needed dialogue on complementary health care services (Leavey, 2012).

2.7 Religion, Spirituality and Health in Zimbabwe

“In Zimbabwe, people visit the traditional healers, the prophets from “Churches of the Spirit,” hospitals, and clinics for medical treatment. Diseases or sickness are viewed not only as physical or psychological but also as religious issues.” Machinga, 2011, p.1)

Reviewed studies show that religious beliefs and practices play a significant role in health and help seeking behaviour (Gureje et al., 2015; Basure & Taru, 2014; Maguranyanga, 2011; Omonzejelel, 2008). Zimbabwe, like many African countries, has a pluralistic health care system where people consult both biomedical and traditional and religious healers (Monteiro, 2015; Machinga, 2011; Campbell-Hall, et al., 2010; Patel et al., 1995). According to Machinga (2011) indigenous healing therapies in the country are provided by traditional and religious healers which include diviners, herbalists, exorcists, traditional midwives, religious spiritual healers and faith healers. The overarching theme in indigenous healing beliefs and practices (both among traditional and religious spiritual healers) is the belief in the existence of a supernatural forces with domineering influence on health and other aspects of human life (Basure & Taru, 2014; Maguranyanga, 2011; Machinga, 2011).

Religious beliefs and practices have a significant impact on the spiritual worldview of the local people (Machinga, 2011; Ganiel, 2010; Gunda, 2007). Basure and Taru (2014) argue that spiritualism, that is, the belief that everything (be it success or misfortune) is influenced by some supernatural forces beyond the human living world, is common across religions, cultures and communities. The belief that an individual can be possessed or oppressed by supernatural spirits, either benevolent or evil, is shared by many communities across the globe. Even though spiritual possession or oppression may vary from one society to another as a result of different cultural beliefs, (since beliefs on spiritual possession and oppression are culturally relative), the common denominator remains the existence of deterministic supernatural forces beyond the living world (Basure & Taru, 2014).

Several studies have also reported that people's health behaviours and lifestyles are closely related to their religious and cultural beliefs (King, et al., 2013; Koenig et al., 2012; Hefti, 2011; Moreira-Almeida, 2006). That is, what people eat, drink or how they spend leisure time, which may in turn affect one's health and wellbeing, is to a large extent influenced by religious and cultural beliefs. For example, the symbolic meanings attached to animals, plants and inanimate objects with regard to what people eat, drink or worship show the importance of and connection between the local people's belief system and health behaviours and lifestyles. In this regard, the various forms of rituals and worship exemplified by fire, water, earth mineral and nature (plants and animals) do not only mirror the predominant beliefs and practices, but also provide a framework of understanding various life issues such as death, wealth, health, illness, success and misfortune (Basure & Taru 2014; Shizha & Charema, 2011).

2.8 Chapter Summary

In Africa, as in many other low-income countries, concepts of mental health and illness are influenced by the African world view of health and diseases which transcends mere organic and tissue malfunctions to include supernatural factors relating to religious, astrological, magical, and ancestral spirits and gods. Although diseases are believed to stem from physical and human factors, there is a firm belief in supernatural causation of mental illness as noted by the commonly reported mental illness treatment methods which rely heavily on spiritual acts of divination, incantation, rituals and sacrifices. The predominant African supernatural explanations of mental illness however differ from the biomedical concepts held by formal and conventional clinicians. These differences in the explanation and treatment of mental illness is further reflected by the pluralistic nature of health care systems in low and middle income countries where mentally ill patients simultaneously traditional and biomedical practitioners.

There is a dearth of information on both the clergy's explanations of and response to mental illness issues in low and middle income countries. Available literature mainly from high income countries report the clergy as upholding modern, bio-psychosocial concepts of mental health and

as being regularly consulted on a range of emotional and psychological problems. In other studies, the clergy were reported as mental health gatekeepers, and in some cases, as the first and only professional that individuals may consult on mental health issues. These consultations were reported as consistent with their ministerial and religious roles and included such matters as bereavement, health, marital and personal problems. The few available studies from low and middle income countries similarly report an increasing trend of psychiatric clients consulting the clergy and spiritual churches ahead of both formal health care system and other traditional therapies.

Religious leaders in both high and low-income countries have been reported to encounter clients who were categorically similar to clients seen by mental health professionals with respect to both the type and severity of psychiatric problems they presented with. Reviewed studies however report minimal clergy mental health training, referrals and collaboration between formal mental health professionals and the clergy since the latter was reportedly not regarded as a partner in mental health care. There is also evidence indicating that clergy beliefs and practices may influence congregants' use of formal mental health care. It is therefore important to understand the process by which mental health issues are understood, identified and managed by the clergy to generate evidence on the clergy and religious factors that promote positive mental health as well as inform mitigation strategies for the negative clergy related factors that hinder the use of formal mental health services.

CHAPTER 3 METHODOLOGY

3.1 Research Design

The current study adopted a qualitative research design aimed at eliciting free flowing textual data on the clergy's conceptualisation of mental illness. Assuming that there are “multiple realities” and that the ‘truth’ is in the informant's perspective (Kisely and Kendall, 2011), free flowing, non numerical data was collected through flexible semi structured interviews. Inductive data analysis was used, that is, meanings emerging from the data were extracted and analysed as themes. In accordance with the rigor principles for qualitative research as proposed by Lincoln and Guba (1985), the current study applied, among other techniques, purposeful sampling, triangulation, member checking, negative case analysis, independent review of transcripts and themes and reflexivity to enhance the trustworthiness of the research findings (Houghton, Casey, Shaw, & Murphy, 2013; Kisely & Kendall, 2011).

3.2 Theoretical Framework

The current study adopts a bio-psycho-social-spiritual model, an extension of the traditional biopsychosocial model propounded by George Engel as a philosophy and a practical guide in clinical care (Borrell-Carrió, Suchman & Epstein, 2004). The model which now incorporates spiritual concepts was chosen because of the increasing recognition of spirituality as an important determinant of wellbeing and social functioning (Leavey, 2010; Koenig, 2008; Farris 2006, Bhui et al., 2003; Schnittker, et al., 2000), as well as the centrality of spiritual factors in local people's explanations for health, illness and diseases (Basure & Taru, 2014; Machinga, 2011; Shizha & Charema, 2011; Ganiel, 2010).

According to Borrell-Carrio et al (2004), the traditional biopsychosocial model ushered a new paradigm and explanation of causation that is more comprehensive and naturalistic than the simple linear cause–effect reductionist models that were previously used to explain clinical phenomena. The model has been widely applied as a way of understanding how suffering,

disease and illness are affected by multiple biological, psychological, social and environmental factors spanning from the individual to the macro societal level. Arguing that biochemical alternations do not always translate into an illness, the model provides a practical understanding of the interaction of biopsychosocial risk factors and patient's subjective experience, as key to the comprehensive understanding and management of human diseases and illnesses (Borrell-Carrio et al., 2004).

Research on the dynamic interplay between biological, psychological, and socio-cultural experiences of human sickness has generated further evidence on the role of spirituality within the biopsychosocial model. The importance of spirituality issues on wellness, health and diseases is increasingly being recognised and reported in both secular and religious sectors (Leavey, 2010; Koenig, 2008; Farris, 2006; Cumella, 2002; Schnittker, et al., 2000). According to Cumella (2002), the addition of spirituality to the bio psychosocial model came about as a result of growing evidence that spiritual beliefs do influence health perceptions, decisions and behaviours. In this regard, spirituality is viewed as a crucial component of the 'psychosocial' part of the biopsychosocial model (Cumella, 2002).

Spirituality is a broad concept stretching beyond the conventional religious meaning (Cumella, 2002). Although spirituality can be conceptualised differently in secular and religious settings, scholars contend that in both contexts it involves a deep search for meaning and the longing for and/or connection with whatever is regarded as sacred to one's life (Cumella, 2002; Hill, 2000). In Christian religious context, spirituality relates to the preoccupation and or connection with transcendent, that is, concept of God, the Divine, whereas in the secular world spirituality mainly relates to psychological beliefs, emotional experiences and socio-cultural issues (Cumella, 2002).

Notwithstanding the foregoing conceptual differences, the extended biopsychosocial-spiritual model offers a comprehensive contemporary explanation for mental illness which addresses some of the shortcomings of the traditional biomedical model. The model offers a multifactorial explanation involving a complex interaction of (i) biomedical and genetic factors, (ii) psychological, emotional, behavioural, and cognitive factors, (iii) social and family factors and

(iv) spiritual beliefs and history (Cumella, 2002). The model proposes that biological, psychological, social and spiritual factors within or outside the individual interact in a complex manner to either increase one's susceptibility to or reduce one's protection against the development of a specific mental illness. Thus a comprehensive treatment package must consider all the above factors in their cultural context as they all have a bearing on the development, experience, explanations and management that specific mental disorder (American Psychiatric Association, 2013, Cumella, 2002).

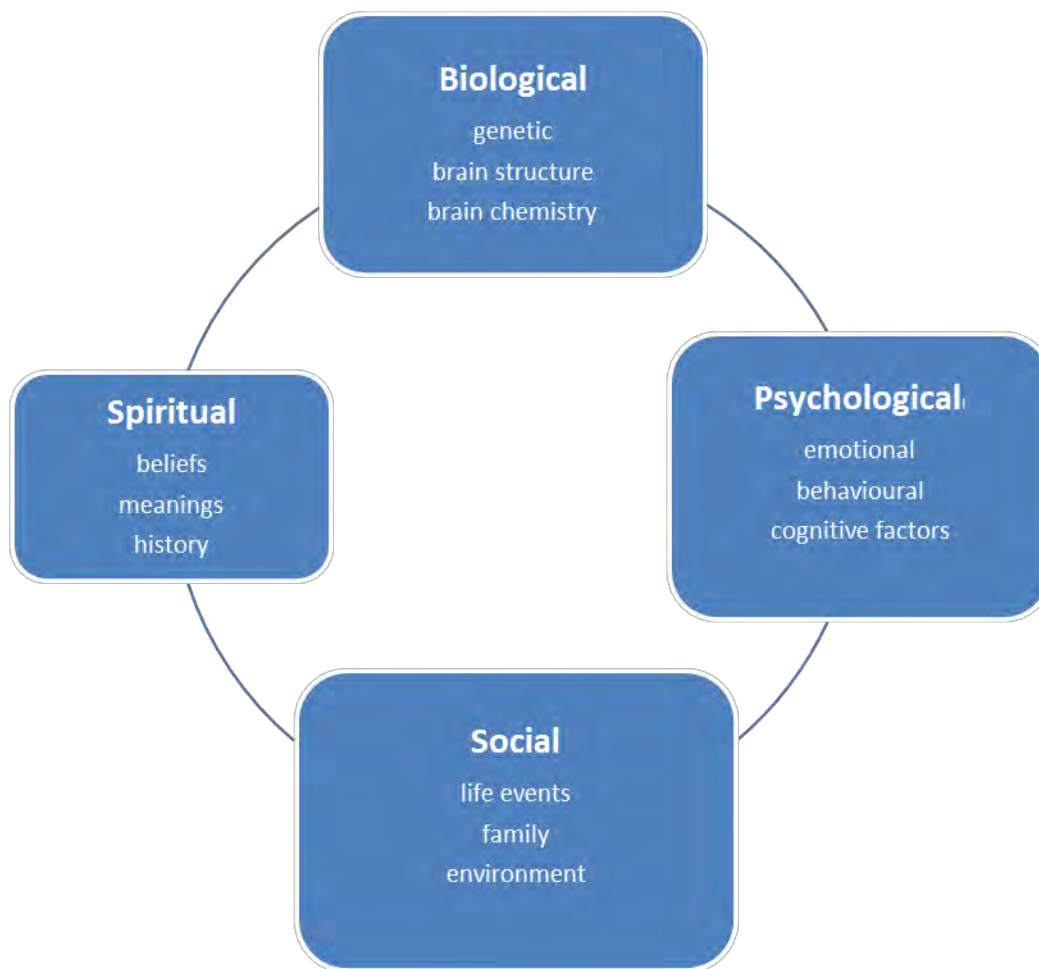


Figure1. Biopsychosocial-spiritual model.

The extended biopsychosocial-spiritual model befits the study's exploration of the clergy's understandings, responses and perceived contributions towards people with mental illnesses.

Firstly, departure and convergence points between secular and religious understandings of mental illness will be explored. Cumella (2002) for example argued that while Christians may agree with secular views on the role of spirituality in mental health and illness, they may disagree with reducing spirituality to simply psychological beliefs, emotional experiences, and church functions. Thus the clergy's concepts of spirituality will be explored in the broader context of mental illness attributions and responses. This is particularly important as there have not been close investigations of the clergy's perspective of mental illness including explanations on how their religious trainings, teachings, beliefs, practices, and regulations were either directly or indirectly influencing community mental health decisions, behaviours and care pathways.

The choice of the biopsychosocial–spiritual model to examine clergy's understandings, responses and perceived contributions towards people experiencing mental illness was also guided by the growing evidence on positive and lasting mental health outcomes derived from holistic approaches of traditional medicine and healing practices in Africa (Gureje et al., 2015; Abbo, 2011; Levers, 2006). This evidence is however against the backdrop of previous negative reports which viewed African indigenous healing traditions through biomedical lenses and concluded that traditional medicine was irrational, superstitious and unscientific (Waldron, 2010; Shizha & Charema, 2011). Chavhunduka (1994) noted that early Eurocentric research ignored the positive elements of indigenous informal treatment approaches and dismissed with contempt traditional healing beliefs and practices. Traditional healers for example, were reportedly criticised for spiritualising diseases and illnesses and were also viewed as barriers blocking the use of modern medicines and formal healthcare services (Waldron 2010; Atindanbila & Thompson, 2011; Chavhunduka, 1994). In view of the reported shortcomings of the biomedical approach and early literature biases that entirely denounced traditional healing practices, the current study adopted a more holistic, and contemporary model to fully appreciate the clergy's biological, social, psychological and spiritual perspectives on mental illness as potential informal mental health care providers. Further, the multidimensional approach of biopsychosocial–spiritual model resonates with current thinking and intervention models such as the task shifting and collaborative models which posit the scaling up of mental health services through the recognition and involvement of other non-specialist mental health providers.

Health care systems in low and middle income countries have been reported as pluralistic where patients simultaneously consult traditional health and formal health workers (Monteiro, 2015; Campbell-Hall, et al, 2010; Ngoma, Prince & Mann, 2003; Patel 1995). Research evidence further indicate a higher preference and patronage among traditional medicine practitioners compared to formal biomedical practitioners on mental health problems (Adewuya & Makanjuola, 2009; Kar, 2008; Ayorinde, Gureje & Rahman 2004). Among the reasons put forward for the high preference and consultation of traditional and spiritual healers on mental illness was the congruent worldview and philosophies on the supernatural causation and treatment of mental illness held by both traditional healers and the consulting patients and their caregivers (Gureje et al., 2015 Basure & Taru, 2014; Abbo, 2011; Campbell-Hall, et al, 2010). Waldron (2010, p.55), for example, examined African indigenous health, illness and healing concepts and noted that “the traditional African worldview is premised on the interrelationship between the living and the nonliving, natural and supernatural elements, and the material and the immaterial.” In this regard, the biopsychosocial–spiritual model present the appropriate lenses through which the reported supernatural (both spiritual and immaterial) factors can be explored vis-à-vis the clergy’s understanding and response to mental illness, and more so, their advice, decisions and behaviours relating to the utilisation of formal mental health care services.

3.3 Sampling procedure

The study participants were identified through purposive sampling, a non-probability sampling method based on the researcher’s knowledge of the population, its elements and the research aims and objectives (Smith & Osborn, 2003). Kisely & Kendall (2011, p 365) contend that study participants in qualitative research “are selected according to their capacity to provide data relevant to the phenomenon of interest, and to inform the emerging theory”. Thus, the researcher was guided by the research question to select participants deemed to provide different perspectives and ranges of opinions that were relevant to the research questions.

3.4 Population and recruitment procedure

The population of interest for the study were practising clergy and religious leaders of Christian denominations in Harare. In view of the diversity of Christian organisation in Zimbabwe twenty

eight participants were purposely sampled from ten different church denominations. To ensure that there was good deal of variety in the resulting sample with respect to key factors such as clergy affiliation, orientation and training; participants were drawn from Mainline, Protestant/Reformed, Pentecostal/Evangelical and African Indigenous Churches and had different work assignments in their respective denominations. The sample included community level clergy, administrators, trainers, and heads of denominations and church coordinating boards. Thus, both internal and external diversity within and among the clergy was used to provide a clear and broad understanding of the clergy's conceptualization of mental illness. The sample size was selected to reach data saturation and to represent variation of perspectives within the target population (Houghton, et al 2013; White, Oelke, & Friesen, 2012).

Formal permission was obtained from the national and or regional headquarters of each denomination to interview the targeted clergy. The researcher could not secure permission from two initially targeted denominations owing to bureaucratic delay and suspicion over the perceived agenda and use of data derived from the study. Eventually, the study participants were drawn from ten different Christian church denominations still allowing an exploration of a fairly heterogeneous sample thereby increasing the range of views.

The participating clergy were defined as pastors, priests, ministers, and bishops, currently serving in their respective denominations. They had varied appointments and responsibilities in their churches which included community level denominational head, theological seminary lecturers, and representatives from administration and apex coordinating boards.

The participants were identified and recruited through denominational headquarters approached to obtain permission to conduct the study in their respective churches. The researcher was given a list of contact details for the church leaders in Harare serving as community level head, theological seminary lecturer and church administration. The clergy who had accessible contact details and voluntarily agreed to participant were included in the study. The clergy residing in Harare but serving at a church located outside the geographic area in question were excluded from the study. Appendix A contains a list of participants.

3.5 Measures and instruments

Face to face interviews were conducted in a non-directive style. A semi structured interview schedule (Appendix B) was compiled consisting of open ended questions and (optional) vignettes, which were used to elicit the participant's beliefs, perceptions, experiences and responses to community mental health needs. The interview schedule was developed based on the purpose of the study and informed by related issues reported in the literature on mental health, spirituality and religion.

The interview schedule included items on the following areas: demographic data, prior mental health training, experiences with people living with a mental illness, conceptualization of mental illness, causal attributions, recognition of mental illness, responses to mental health needs, perceived ability to provide services, aspects of pastoral care for persons with mental illness, role of the church, formal health care system, contact with other mental health services providers and suggestions and recommendations on the treatment and care of people with mental illness. The interview structure allowed for varied responses by posing general open ended questions first then following up with probes to further explore the responses. Appendix B provides the interview schedule used in the study. The interview schedule was piloted to ensure that both the expressed and implied meanings of the questions were understood.

The optional vignettes and follow up questions were adapted from the MacArthur Mental Health Module of the 1996 General Social Survey (Pescosolido et al 2000). The decision to include the vignettes as an optional section was made following challenges noted during the pilot test as explained below. During the pilot test, participants were first presented with three vignettes each describing an individual with symptoms consistent with each of the following conditions; schizophrenia, major depression and alcohol dependence. The main purpose of the vignettes was to generate a broader discussion on mental illness. The MacArthur Mental Health Module survey vignettes and follow up questions were selected because the vignettes' symptom description were consistent with the Diagnostic and Statistical Manual of Mental Disorders (DSM IV) (Schnittker, Freese, & Powell, 2000; Pescosolido et al 2000). After the pilot study, a decision was made to use the vignettes only when the participant indicated that he/she had no prior contact or experience with people with a mental illness. In this regard, the vignettes were not

used in the main study as all the respondents reported prior contact with and gave detailed accounts of their experiences with mentally ill persons.

3.6 Pilot Study

Kim (2011, p.191) defines a pilot study as a “small-scale methodological test conducted to prepare for a main study and is intended to ensure that methods or ideas would work in practice”. In other words, a pilot study provides the researcher with an advance signal on the appropriateness of the methods to provide an opportunity to make adjustments and revisions in the main study. Kim (2011) explains that pilot studies serve a number of functions including testing of the research protocol (such as a data collection method and a sample recruitment strategy); assessing the feasibility of the research process (that is, the acceptability of the interview, socio-cultural and political context of the study); assess the readiness and capability of the researcher, and the identification of specific methodological, ethical, and logistical issues that may impact on the research process.

A pilot study was conducted to assess the interview schedule, competence of both the researcher and research assistants, and to uncover any practical difficulties that could derail the main study. The pilot exercise was conducted after the Ethics Review Committee approval. Four clergymen in Harare were purposefully selected for the exercise. Two research assistants interviewed one respondent each while the principal researcher interviewed the other two respondents. The interviews were conducted in English, that is, the respondent’s preferred language and at a venue suggested by the respondents. Each interview was audio recorded and thereafter the interviewer transcribed, coded and presented the data to the other interviewers. Discussions were held on the interview schedule, interview process and the data outcome resulting in the following changes:

- a. The interviewers found that the clergy who had exposure or prior contact with people experiencing mental illness responded as if they were being evaluated on their knowledge and understanding of the conditions presented in the three vignettes rather than to simply express their views on mental illness in general. The interviewers therefore agreed to first pose an open ended question “Have you ever had close contact or any experience with mentally ill people” before presenting the vignettes. If the respondent indicated prior

contact or experience with a person who had mental illness, follow up probes were made on the presentation, causal attribution, perceived seriousness of the problem and assistance given. The interviewers could ask up to three such experiences. If the respondent indicated that they had no prior contact or experience with people with mental illness, the three vignettes would be presented to guide and broaden the discussion. Thus the vignettes were set aside and reserved for use only when the clergy indicated that he/she had no prior contact or experience with people suffering from mental illness.

- b. Although training on data collection was conducted with the research assistants prior to the pilot study, some variations were noted on the questioning and interpretation of the interview guide during the pilot study. Therefore to enhance the trustworthiness of the data by reducing interviewers' variability and improving consistency in data collection, all the interviews in the final study were conducted by the principal researcher.

3.7 Data collection and management

3.7.0 Consent

The participants were asked to express their willingness to participate in the study by signing the informed consent form. The consent agreement form detailed among other issues:

- The purpose of the research
- The procedures of the research
- The risk and benefits of the research
- The voluntary nature of research participation
- The respondent's right to stop the research at any time
- The procedures used to protect confidentiality

Only respondents who voluntarily agreed to participate by way of signing the informed consent form were included in the study.

3.7.1 Data collection

Twenty one interviews were conducted in English while seven interviews were conducted in Shona, a local and first language for both the respondent and the interviewer. Each interview took approximately 60 to 90 minutes and was held at a venue suggested by the respondent. All the interviews were audio recorded with permission of the respondents and were assigned separate identification codes.

3.7.2 Data Analysis

Data analysis commenced with transcribing and cleaning of the data. The audio-taped interviews were transcribed by the research assistants and transcriptions were reviewed by the principal researcher. The seven Shona interviews were first transcribed in vernacular language by the research assistants and were then translated to English by an experienced translator and court interpreter. The interviews were then analysed through thematic analysis, a method for identifying, analysing, and reporting patterns (themes) within data. An initial coding frame was developed to capture identified themes and subthemes.

The following data analysis process was adopted

- a) The researcher familiarised himself with the content of the interviews by ‘repeated reading’ of the data, searching for meanings and patterns (Attride-Stirling, 2001).
- b) A framework analysis approach (Smith & Firth, 2011) was then used to develop a coding framework. Units of conceptually related text were assigned to some codes. The codes were organised into basic themes; which were assimilated into broader or more abstract themes, which in turn were then organised into higher order super-ordinate themes encapsulating the principal meanings, assumptions and implications of the data. (Attride-Stirling, 2001). The codes selected for inclusion in this initial framework was guided by the research question, sub-questions and common issues emerging from the text. The breadth and depth of the initial coding framework was then checked against the codes developed by two independent qualitative data analysts. The final coding framework was used by the principal investigator to code all interviews line by line using NVivo version

10 qualitative data analysis software. The transcripts were multi-coded on the basis of salient coding themes. Emerging themes were incorporated into the coding frame as the analysis progressed. The coding framework is listed in Appendix E.

- c) The coded themes and subthemes were systematically assembled and organised into basic themes; followed by more abstract organizing themes and then lastly the higher order super-ordinate themes encapsulating the principal meanings, assumptions and implications of the data (Attride-Stirling, 2001).
- d) The principal themes were summarised, integrated and interpreted in relation to the research questions and objectives, in a narrative report.

Validity checking was conducted shortly after the final analysis and preliminary report by availing the report to the respondents to determine if the essence of the interviews were correctly captured and presented. Three respondents reviewed the preliminary report. The report was also presented for validity checking to two independent data analysts who were involved in the review of the transcripts and development of the coding frame. Issues raised were deliberated and accordingly modified in the final report.

3.8 Trustworthiness

According to Padgett (2008: 86) qualitative researchers carry a number of identities such as professional, personal, political into the field and these identities do influence the research process. This observation therefore calls for the researcher's sensitivity to own beliefs, values, opinions and decision to guard against contaminating participants' perspectives of the matter being investigated. Thus the researcher has to be conscious of and aside or bracket own beliefs, values, opinions and preconceptions regarding the phenomenon being investigated, and therefore view the phenomenon through the eyes of people being studied.

In the current study, the researcher endeavoured to be as open and receptive as possible to the respondents' reported experiences. The researcher maintained a reflective diary detailing the decision trails, procedures, thoughts, ideas, feelings experienced during the research process. Apart from providing the above research trail the researcher was aware that his professional engagement as national coordinator for a local mental health association could impact on the

research process. The researcher therefore maintained a neutral stance throughout the research process, for example, was careful not to display or disclose his affiliation and involvement with the mental health association. In addition, all observations falling outside the immediate scope of the study but of interest to the researcher's professional engagement as a mental health coordinator were noted separately in the reflective diary for later follow up to safeguard the entire research process against the otherwise competing interests likely to influence data collection and interpretation. Further, two independent qualitative data analysts who worked with the principal investigator reviewed the interview transcripts, developed the coding frame, and also contributed to the validity check by reviewing the preliminary report.

There are different criteria used to assess the trustworthiness or rigour of qualitative research (Houghton, Casey, Shaw, & Murphy (2013). Trustworthiness in the current study was framed on the Lincoln and Guba (1985) four criteria of credibility, dependability, confirmability and transferability. A brief illustration on how the above four processes were applied to determine trustworthiness in this study is outlined below.

Credibility: Purposive sampling was used to select participants with the capacity to provide credible data relevant to the phenomenon under investigation. Further, a wide sampling, thick descriptions, use of respondents' vivid voices, negative case analysis, and member checking were applied to enhance the richness, accuracy, and extensiveness of data as well as its interpretation from the respondents' perspectives.

Dependability and confirmability: This was achieved through consistency in data collection, systematic data analysis and the reflexive diary documenting the research process. To establish consistency in data collection, all the interviews were conducted by the principal researcher. As described in the data analysis section above, a systematic and comprehensive, step by step thematic analysis was employed to discover the full range of both dominant and subordinate themes. A conscious attempt was made to ensure that data interpretation and conclusions were accurate, reflect participants' perspective and contextually rich by including the voices of

respondents in data analysis and interpretation, coupled with the researcher's emersion into the data and the use of rigorous and systematic research methods.

3.9 Ethical Considerations

The researcher obtained prior approval from the Research Ethics Committee of the University of Cape Town, South Africa as well as the Medical Research Council Zimbabwe's approval to conduct the study.

The researcher further sought permission from headquarters of the participating church organisation to interview the targeted respondents. Respondents who agreed to participate were fully informed about the purpose and benefits of the study, nature of the interview and their rights as participants. The respondents were further assured that their names and identities would remain anonymous and confidential throughout the research process.

The researcher was aware that the research could pose very minimum risks to participants, that is, discussions in the interview could make some participants feel uncomfortable or upset. Participants were therefore advised to bring to the researcher's attention any feelings of discomfort and to choose which questions they feel comfortable to answer as well as their right to stop the interview at any point. In addition, the researcher would debrief participants who report being distressed by the interview process. However, besides some occasional emotional comments on past experiences with mentally ill persons, neither overt nor covert emotional distresses were registered and none of the participants opted to end the interview due to the increasing distress.

Chapter 4: Results

This chapter presents the dominant clergy beliefs and explanations for mental illness, the process by which the clergy identify and manage mental illness and the perceived role and contributions of the church to community mental health.

4.1 Respondents

Twenty eight in-depth interviews were conducted with four theological seminary lecturers, eighteen community level church leaders (that is, pastors, priests, ministers and bishops) and four apex boards' members for Mainline churches, Pentecostal churches, Protestant churches and Indigenous Apostolic Churches (Appendix A list of the respondents). Twenty six of the respondents were males and two were females. The majority of respondents had tertiary level training (n=22), majoring in theology (n=21). Further, 13 of the respondents with tertiary level training had other tertiary qualifications which included education (n=2), bachelors and masters degrees in humanities (n= 7) and doctorates in theology (n=4). Six respondents without tertiary level qualifications were educated up to the Zimbabwe secondary school education, that is, ordinary level education (n=4) and advanced level education (n =2).

4.2 Conceptualization of mental illness

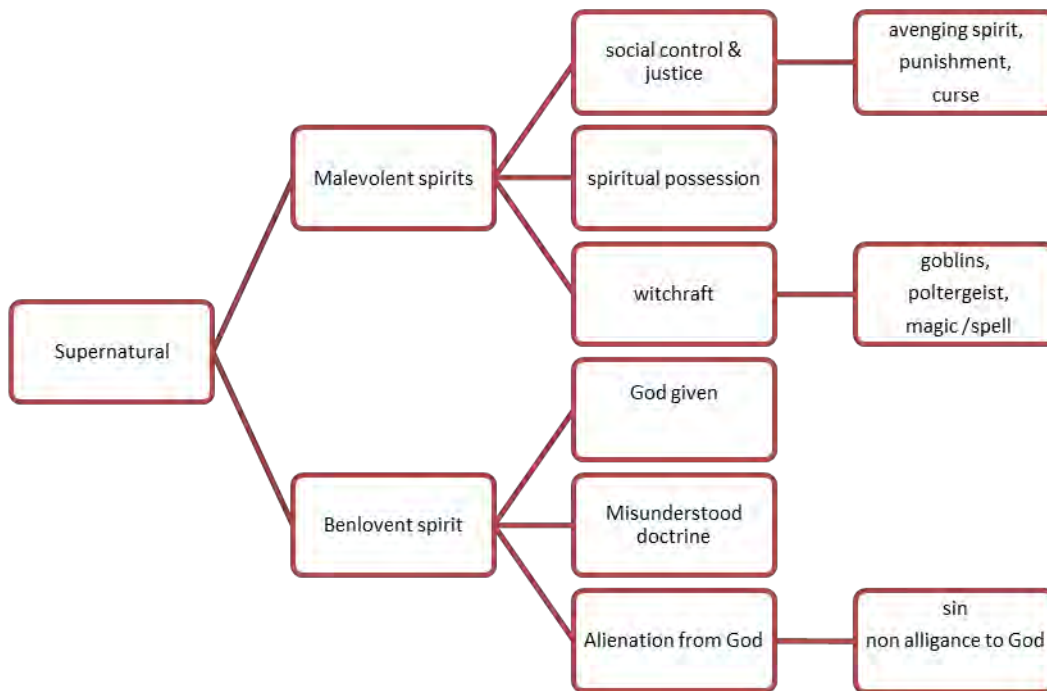
Mental illness was broadly conceptualized as a multi-factorial phenomenon attributed to both supernatural and natural causes. The most common supernatural representation of mental illness was the influence of malevolent spirits while psychosocial and biological representations dominated the natural representations of mental illness. The tendency to spiritualize mental illness was common among participants' descriptions of their clients' presentations and their subsequent response. The church was perceived as strategically positioned and endowed with vast resources to promote the wellbeing of persons with mental health problems. (Appendix F: Summary of main representations, domains, themes and subthemes).

4.3 Supernatural explanations of mental illness

The clergy attributed mental illness to supernatural influence of either benevolent or malevolent spirits that were believed to exert their influence over the individual. According to the malevolent perspective, mental illness was regarded as a manifestation of evil spirits. The clergy attributed mental illness to spiritual attacks and possession by some malevolent spirits, “demons” that “occupy the person’s mind” thus resulting in mental illness. These malevolent spirits torment people in various ways with or without explainable causes.

On the other hand, clergy reported that the benevolent Holy Spirit works to restore good health and the quality of life for those who profess allegiance to God. However, ill-conceived beliefs about benevolent spirits would either contribute to the development of mental illness or complicate the treatment of an existing mental health problem. Both malevolent and benevolent spirits were reported to be originating and operating from either the supernatural or natural worlds. Figure 2 depicts the supernatural representation of mental illness.

Figure 2: Supernatural representations of mental illness



4.3.1 Mental illness as a form of spiritual control and justice

Mental illness was viewed by several respondents as a means of instituting justice, for example, one respondent said that this would occur following a “wrongful act by someone in your family ancestry, for example, the victim’s family might have killed someone”. The wrongful act was believed to give the vindictive spirit “a legal right” to torment and pressure the perpetrator’s family members to make compensations. One of the respondents explained the circumstances believed to have caused one of the congregants to be mentally ill as follows:

“It was said that his family once had a casual labourer from Mozambique who passed on whilst staying with the family. There were stories that the family had not paid him {deceased laborer} wages some saying they did not hand over his personal belongingsSo it was the spirit of this person {deceased labourer} that was manifesting and tormenting him”(MET2)

Similarly, some respondents reported mental illness as a form of punishment for partaking in unlawful acts of theft, adultery or violation of social norms.

“Another form of witchcraft for example if you steal from clever people, those who are involved in magical charms....you will run mad.....I have heard of some and also shown some mad people because it was said they had stolen from clever people” (MET3)

Although the majority of the clergy believed that this form of illness could be reversed through deliverance prayers or exorcism, others felt that reparation must be done to the aggrieved family if the sufferer is to be completely relieved of the spiritual influence and regain normal mental functioning,

“Kupedza ngozi huiripa (an avenging spirit can only be appeased by meeting its payment demands). Avenging spirits do not need prayers, they want to be paid”. (JM1)

One respondent underscored the need for collective family intervention as individual prayers were said to only result in temporary relief of the afflicted individual. If the afflicted person is continuously prayed for, the tormenting spirit would temporarily leave the individual but occupy another member of the family. Therefore a collective family intervention would be required.

“Some of the mental illness as I said need the family members to sit down and attend to the root cause of the illness, if it means settling whatever need to be paid or perform some rituals they have to do it collectively as a family”.(MET2)

4.3.2 Mental illness as spiritual possession

Several respondents attributed mental illness to foreign evil spirits which might attack vulnerable individuals without them having done anything wrong. Respondents explained that the reason of these attacks was mainly to ruin the person's future, career, business, and family social relations or even prematurely end the individual's life. These spirits would also prowl vulnerable individuals and establish their dwelling place within them and thus taking control of that person's life. According to the clergy, the domineering influence of the evil spirit and the subsequent loss of control over one's mind and life were an indication of the evil spirits' triumph in the battle to rule over the individual's life.

“This is the work of the devil. When the devil rebelled against GOD, he was thrown down on earth without a body. So this spirit is wandering around looking to a body to occupy and operate from. So when the spirits occupy a person he can be mentally ill.... ”. (LDS1)

According to the clergy, these roving spirits target and occupy persons who either have distant relationships with GOD or had expressed some kind of allegiance to the “underworld spirits” through, for example, the person’s beliefs and practices including spiritual rituals.

“There are also some evil spirits ‘mamhepo’ which can cause mental illness. I know of a girl who would behave very unusual when these spirits invade her.....we prayed for her and at times invited her to church when she is normal to discuss her problems. From the discussion she reported to have been once involved in family rituals....”(LDS1)

This form of mental illness was believed to be treated through renunciation of underworld spiritual beliefs and practices as well as repentance and adoption of Christian beliefs and practices.

4.3.3 Mental illness as a result of witchcraft

The third representation of mental illness was conceived to be man-made acts of witchcraft which target and harm the individual through “mamhepo” evil spell; *chikwambo* poltergeist spirit, “*zvishiri*” goblins and *zvitsinga* magical charms. The bewitching party for example would through acts of witchcraft, take away and use the target individual’s mind thereby ruining the target person’s life and business. It was further believed that when the wellbeing of afflicted individual is going down the life and business of the bewitching person will be prospering.

“Chikwambo is a magical charm meant to prosper business....I mean when the person becomes mentally ill the chikwambo would have colonised or took the brains of the individual so that he will not be able to do his own personal business but will be indirectly used to boost the business of the chikwambo owner”.(JM2)

“Mental illness is also due to goblin attack ‘zvishiri’. Goblin attacks can result in either physical disability or mental disturbance. Traditionally these goblins were used in hunting to hit and paralyze animals but now they are being used against people”(UGFAC1)

It was reported that, out of jealousy, conflict, or the need to amass wealth, people get bewitchment powers and charms from the witchdoctors to harm an individual deemed successful or whom they had been prior conflict or unresolved disputes. In such circumstances, bewitchment will be used as a way of settling personal disputes, revenge or exerting social control by causing the bewitched individual to be mentally ill. This was deemed a very harsh way of settling disputes as mental illness was viewed as the most painful and embarrassing illness, not only to the targeted individual, but the whole family.

“In most cases mental illness is due to witchcraft. You know in the communities, some people become jealousy of the success of another person, or it could be just hatred or some grudges so they will bewitch that individual to be mentally ill”.(JM2)

The witch doctors were reported to be clandestinely involved in the process by first conspiring and assisting people practising witchcraft to cause the mental illness and then “act like an innocent redeemer” when later consulted by the victim’s family to treat the mental illness. Through such underhand dealings, witchdoctors would cash in during the process as receive payment from both the person practising witchcraft and later the victim’s family.

“...the afflicted person or his relatives will eventually come to them {witchdoctors} for assistance hence they get paid for withdrawing the affliction they would have caused”. (UGFAC1)

Divine healing, deliverance prayers and exorcism were the most common reported methods for helping the afflicted individual.

4.3.4 Benevolent explanations for mental illness

Respondents expressed belief in a sovereign God whose dominion is exercised through the benevolent Holy Spirit. God was reported to be all loving, having good intention to all mankind and that it was through the love of God that man enjoy good physical and mental health, lead a meaningful life and protection from evil spirits. According to the benevolent perspective, mental illness can be attributed to the will of God, alienation from God or from holding maladaptive beliefs about God and/or the devil.

4.3.5 Mental illness as “GOD given”

Several respondents shared the belief that some people were born mentally ill because God predestined them to live like that. Mental illness was therefore considered the will of GOD. However, this cause was not ascribed to all forms of mental illness but only those cases where one was born with mental abnormalities, that is, intellectual disability. It was further believed that recovery was rare and usually through miraculous healing otherwise nothing much could be done to change the situation.

“But with some problems like my brother’s son {reported earlier in the interview as born intellectually disabled mentally challenged} one just need to accept the child as he is as a gift from God. There is nothing much that can be done to change the situation. It’s God given. (SDA1)

Another respondent said

“I believe some of these illnesses {mental} God has a purpose because some people are born like that and may grow up and live their entire life with mental challenges”.(LDS2)

4.3.6 Mental illness as a result of misunderstood doctrine

It was reported that a misunderstanding of the teachings of the church could result in personal religious beliefs and practices which could impact on mental illness among congregants who ill-conceive the supernatural influences upon their lives. One of the respondents noted that

“..... wrong understanding of faith or spirituality can also result in psychological problems or illness, for example, an exaggerated concept of the devil, evil spirit, very poor understanding of the love of God , this can also create psychological problems in the person”.(RC4)

Other respondents felt that past negative life experiences such as disappointment following unanswered prayer or advice from the church leaders could result in disillusionment, hopelessness, and in some cases behaviour which could trigger or worsen mental health problems

“This person was given false hope, that is, was convinced to stop taking her {HIV AIDS} medication and to believe God for a miracle that is divine healing for her HIV illness so her condition and situation started to deteriorate and started to have some kind of confusion, talking to herself and at sometimes could not recognize her children. She got mentally disturbed and at that point the relative took her to hospital and was then treated”(AFM1)

4.3.7 Mental illness as a result of alienation from GOD

Several respondents attributed mental illness to alienation from God either as a result of sin or non-allegiance to God. According to the clergy, human beings are spiritual, and naturally inclined to maintain a close relationship with God. However, people often behave or lead lifestyles which distances them from God. When this happens, the individual can be emotionally overwhelmed by the perceived cut-off from God, the subsequent feelings of emptiness and the sense of vulnerability due to lack of Divine protection. One respondent said

“... sin in my understanding does not directly cause mental illness. ..when one commit a sinful act, the person is isolated, alienated from both God and man. The person may start to feel guilt,

isolated and distressed. If this continues, that is, the person does not seek peace with both God and man, he may end up being mentally ill'.(LDS1)

4.4 Natural representation of mental illness

The clergy noted various natural explanations for mental illness that can be equated to the contemporary bio-psychosocial model. As summarised in Figure 3, respondents were of the opinion that mental illness can naturally occur as a result of either biological factors such as genetics, brain damage, biochemical factors and psychoactive substances or psychosocial factors such as emotional trauma, relationship problems, negative life styles and life challenges.

4.4.1 Biological representations of mental illness

The most common representation in this category was the abuse of psycho- active substances. The frequency with which psychoactive substances were mentioned possibly suggests that most respondents were either aware of the long-term impact of psychoactive substance abuse or had come across several people who had substance abuse related problems. Further, a range of psychoactive substances were also mentioned suggesting that substance abuse could be a common problem being encountered by the clergy or was closely associated with the occurrence mental illness. One of the respondents reported that

“What I have said are common traditional causes, nowadays I see different causes on children, for instance, I once met a child grimacing his face and when I asked what was wrong I was told that the child usually takes “ngoma” illicit beer, but on this particular day he had not. So this is another form of spiritual influence which is causing mental illness among children. Children will become very wild, walking in rags as they would be intoxicated and this will affect his brain and body”.(JM1)

“...abuse of alcohol and other drugs such as sniffing glue or smoking marijuana can cause mental illness”.(ZCC1)

“Yes there is this brother again who was affected by drugs whilst in South Africa. It was said that he used to abuse some drugs and as a result his brains were damaged”.(LDS3)

Figure 3 Natural representation of mental illness



Damage to the brain or “brain nerves” was noted as one of the causes of mental illness. This damage was reported to be mostly resulting from the abuse of substances as well as other less mentioned causes such as road accidents, stroke and other head injuries.

“There are many causes like damage to the brain as what happened to my son. It was a case of negligence by the nurses because the child fell and had brain damage. However others are born having these mental disabilities just like any other form of disability. I have also heard that some chemical imbalances in the brain can result in mental problem if these chemicals are not monitored and controlled”.(EFZI)

Among the less frequently mentioned biological causes of mental illness were physical illnesses, genetic factors, giving birth, poor brain development, abnormal brain structures and biochemical

imbalances. A few respondents mentioned chronic physical illnesses such as HIV AIDS, Tuberculosis and ‘heart’ problems as possible causes of mental illness. However among the respondents who made reference to physical illnesses, only one was able to explain the relationship between the physical illness and mental illness as follows

“ Also nowadays if a person gets HIV positive and fails to accept like become very bitter or be in denial, that person may become affected psychologically and may end up mentally disturbed.”(MET2)

The other respondents could not precisely explain the mechanisms by which physical illness could result in mental illness. Some of the lay explanations given, though lacking in detail, were based on past observations and experiences. For example, a clergy who mentioned TB said

“nowadays we have people suffering from TB, I do not know how this happens but I have seen some people with TB getting mentally ill”,(JM1)

Another respondent who mentioned heart problems made reference to indigenous traditional beliefs that was commonly shared by the villagers. Although the descriptive presentation of the sufferer was more like someone experiencing bipolar disorder, the respondent attributed the abnormal behaviour to the heart as follows

“I had a relative at one time and he behaved like a mad person. But the village people believed it was a heart problem, they used to say ‘adhuvala mtuma’ meaning he is ‘sick of the heart’ so we used to take this person to hospital several times.(MET3)

Mental illness was also conceived as intergenerational. However, respondents could not precisely spell out whether it was due to familial genes or other family related factors. For example, one respondent believed that mental illness was an ancestral family issue *“ndomapengero avanoita mudzinza mavo”*, meaning the type of mental illness was typical in the sufferer’s family lineage. No further explanation was given on what makes the family prone to that particular illness.

Interestingly, one of the respondents, an indigenous apostolic church midwife reported that *“I have also seen some women getting mentally ill after delivering babies”(JM1)*. This was possibly

related to the underreported maternal mental health problems such as post-natal depression or puerperal psychosis.

The suggested treatment methods for mental illness believed to have occurred naturally was remarkably different from the treatment of supernatural forms of mental illness mentioned in the previous sections. The clergy endorsed bio-medical treatments methods to mental problems deemed to have a natural or biologic basis.

“However if the problems are due to damage on one’s brain, for example maybe the person had an accident or the brain was damaged by drugs, the church has little it can do because they need medical treatment. So the church would encourage the person or relative to seek medical treatment”.(LDS1)

Importantly, references were made to “psychiatric hospital” and “specialists” suggesting that some of the respondents were aware of and delineate treatment of mental illness from other physical illnesses. In this regard, respondents had a fair understanding of the bio-medical care and that within the health system there were some designated sections and staff who deal with mental illnesses.

Further, the clergy underscored the need for combined spiritual, psychosocial and biological interventions to effectively manage some of the mental illnesses. For example one of the respondents emphasised the need for an integrated, multisectoral response system to substance abuse related mental problems;

“Also the police need to be involved and give support..... for example to young men on drugs sometimes as church you feel you will not be able to assist without police assistance; like the police need to control drug circulation in our communities”.(SDA1)

4.4.2 Psychosocial representation of mental illness.

Psychosocial factors such as poverty, financial challenges and stressful life events such as violence, abuse or trauma were reported as common causes of mental illness. Respondents reported that when one is subjected to stressful life experiences, the person may fail to withstand the pressure, become emotionally overwhelmed and eventually break down. Explanations given were very much in line with concepts of resilience and human limitations to overcoming psychosocial challenges.

“Some people, because of too many life problems, they will not be able to cope, and in thinking too much, their brain somehow gets mixed up and the person becomes mentally disturbed. (AFM1)

“Mental health issues in Zimbabwe should not be viewed in isolation, for example, the economic situation and access to basic health care exacerbate mental health problems (RC2)

Further commenting on the effect of socio-economic challenges on people’s mental wellbeing and how the church is supposed to respond, one of the respondents summed it as follows:

“..... the economic situation that people are living in, people are stressed, people are bitter, they do not know what to do, they are struggling to make ends meet. So we are saying as a church, it should not just be a matter of treating symptoms but you also need to work to address the structures that are creating poverty”.(AFM4)

Another common cause of mental illness as reported by several respondents was unsatisfactory and conflictual family relationships. Marriage especially in a patriarchal society was described by one respondent as “an inescapable trap” in which the abused wife would find it “not easy to get protection from outside”. Marital abuse was therefore reported as a common occurrence and most frequent reason for clergy consultations

“.....if one is being abused in a system in which it may not be easy to get protection from outside, for example married women who is physically abused she may experience a lot of trauma which may cause mental disturbance.(AFM1)

“ Among families I have noted that as humans we make a lot of mistakes, a lot of promises which we fail to fulfill ... There is a lot of distress and violence within families which may result in people getting depressed”(ANG1).

“I have counselled a number of couples especially married women who were being abused for example through domestic violence and some brought infidelity issues whereby the other couple becomes worried that they may have been infected by HIV” (SDA1)

Psychological traumas resulting from adverse emotional experiences were mentioned as potential causes of mental illness. These include, childhood abuse and neglect as noted below;

“....abuse that could be happening in the families especially during childhood as well as lack of care and support from the families and relatives for instance the person may be an orphan and when relatives are not forthcoming to support this individual, he may start to behave abnormally like a mad person”(AFM2)

Further, traumatic experiences during war, sexual abuse and unresolved guilt following a malicious act were also reported to be emotionally draining and could result in mental illness.

“ One time I had a very serious case of a girlthe mother passed away and she was very disturbed...the witchdoctor said the person who caused the death was in the village... they agreed that the person should also die. When they were coming back.... {they}were told that the very person who was named by the witchdoctor had died. So the girl believed it was herself and aunty who had caused the death. This continued to haunt her, she could scream at night seeing this person coming to revenge.she came to me and explained what was happening and I realized she was thinking too much and feeling guilty....”(MET2)

Variations were noted in the clergy explanations of the effect of past malicious acts on the perpetrator's mental wellbeing. While some clergy believed that the perpetrator would be mentally disturbed as a result of magical spell cast upon him as punishment, others attribute the perpetrator's mental distress to subjective self-reproach and the distressing memories of the past malevolent actions

“not because it was ngozi (punishing avenging spirit) but the cruel thing they did, they have persistent guilty feelings”(RC1)

A few respondents mentioned personal factors such as individual beliefs and lifestyles as contributory factors to the development of mental problems. Lack of personal confidence, weak Christian's beliefs and practice, and strong belief in evil spirits were reported for example by one priest as related to mental illness.

“At one time I lived at this particular school and many school girls had these ‘mamhepo’ but to me it was more like hysterical response to stress, that somebody caught out with something so they will go this mamhepo thing to avoid punishment and this was very common when examination time was approaching”. (RC1)

Further, from the teachings which some of the clergy reported, they mentioned that indulgent behaviours were associated with a host of psychological problems later in life

“When we preach to the people we are saying people should desist from lifestyles and behaviours that will later cause mental illness...we are also saying to the community does not behave immorally, do not indulge in drunkenness and do not abuse each other.....”(AFM1)

4.5 Clergy perceptions on the management of mental illness

4.5.1 Perceived role of the church

The church was perceived as a community gatekeeper involved in various activities with individuals, families and the general public. In this regard the church was reported as having a considerable stake in promoting congregants' health and wellbeing.

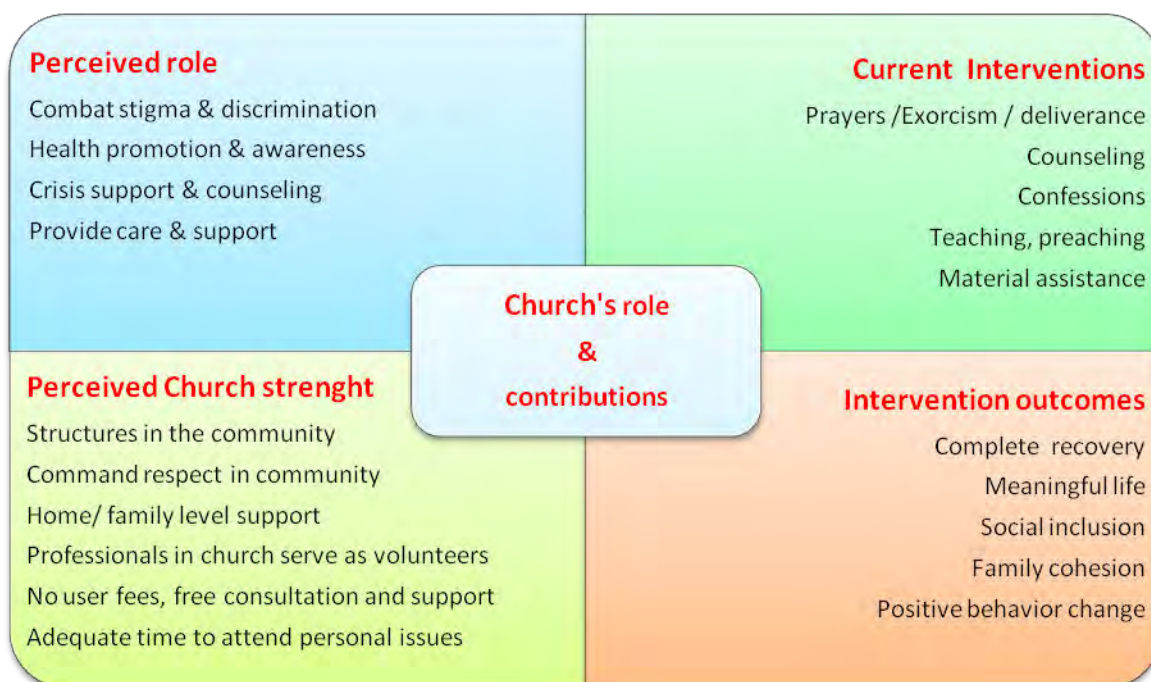
“The church has a big role because many of the problems people face are social. You find that a person may have money, respected social status, but those things alone cannot bring joy or satisfaction so it's only the church where one can get joy, peace of mind, and satisfaction. Church is the only institution that offer security and meaning to human life, cultivating good relations within the family, promoting positive and health lifestyles...(ZA2)”

With reference to the church's historic involvement in health issues, some of the respondents pointed out that the church in Zimbabwe had made considerable community investment which include establishment of social amenities such as hospitals and schools.

“With regard to health issues, as you may be aware, more than 50% of the country's hospitals were built by churches. So the church has for long being active in health issues.”
(EFZI)

Further the church was perceived as an indispensable organ providing the medium of change in the community. The church was perceived as contributing to combating stigma and discrimination, health promotion and awareness, crisis support and counselling, and the provision of care and other support to vulnerable populations including people with mental health problems as summarised in figure 4 below, and detailed below.

Figure 4 Church's role and contribution



4.5.2 Combating stigma and discrimination

The church was reported as having a significant role to play in addressing stigma and discrimination suffered by people with mental illness. It was noted that mentally ill people were often blamed for their illness, fanning pervasive stigma and discrimination both within the church and in the general community. Respondents noted

“There is a lot of stigma that is associated with these problems so the church has a role to play in promoting positive attitudes by showing love, acceptance and inclusion of people with these problems in church programmes and activities”.(EFZ1)

“These people are often blamed for their illness, for example other people believe that they may have stolen, killed other people and so forth.”(SDA1)

Worth noting was the realization by a few respondents that stigma was rampant in the church and therefore attitude change has to start from within the church. One respondent for example reported stereotyped and discriminatory beliefs and practices which fuel stigma, discrimination and marginalization of people with mental illness in the church.

“...where I’m serving at the moment, we have a young woman who has been on {mental} medication since 2000. She is not violent but the way people look at her clearly show they have some issues It’s the same with depressed people who end up hanging themselves and I have heard people preaching as if a person suffering from depression has ‘mamhepo’ and because he hanged himself will not go to heaven”(MET1)

4.5.3 Health promotion and awareness

A number of community health promotion programmes were reported to be collaboratively ran by the church and government and civil society organisations involved in community health

issues. For example, respondents reported collaborations with health personnel on such issues as nutrition and child care, HIVAIDS, immunization, and cholera. However, none of the respondent reported a current or past programme on mental health. One of the respondents noted

“We have health department and this department do invite health personnel to discuss various health topics. However, we have never had anyone educating or giving information on mental health”.(MET2)

This glaring gap was noted and respondents were quick to suggest activities the church could be involved in to raise awareness and support people experiencing mental health problems. For example collaborative community outreaches were suggested capitalizing on the existing church-community structures as well as the church’s reputation and wide community acceptance evidenced by its capacity to gather large crowds of people together.

“the church could play a significant role in terms of raising awareness on what mental illness is, also detaching it from spirituality.....educating pastors, caregivers, pastoral career to be on the lookout for mental health anddemystifying mental ill health, taking away the stigma and even building the capacity of health workers to deal with spiritual needs and religious issues of mental health”. (RC1)

4.5.4 Crisis support and counseling

Another important role of the church expressed by most respondents was offering counselling and crisis support services to people experiencing various life problems. It was reported that clergy were consulted on such issues as marital problems, abuse and neglect, poverty and financial crisis, bereavement, substance abuse, physical health and mental problems. In this regard, most of the respondents felt that the church could provide the initial psychosocial support and in some cases comparative counselling services.

“You can note this {clergy consultation} for example among people who are depressed, bereaved, or experiencing marital problems, or abused, before reporting the abuse to the police for example, they always come for counselling or support. So just being there for people undergoing these problems means a lot to them.....”(RC CBC)

“We have time to discuss issues, doctors only see people 15 minutes but I as a pastor, I see people for an hour”(MET1)

“I can say a community pastor might have three cases of counselling every week. However this counselling may not always be formal. We also do informal counselling and this is what is done in most cases”. (ZA2)

4.5.5 Providing care and support

The church was further perceived as a fountain of emotional and psychological care and support to people experiencing various problems including mental illness. Importantly, the church was perceived as having the capacity and resources (both human and material) to provide care and support to people with mental illnesses.

“Also the church is made up of people with various professional backgrounds some of them are health professionals who if given the support may be able to assist fellow congregants with mental health problems. (ZCC1)

Another respondent reported church support as follows

.....one member in the church, now deceased, used to take these mental drugs but more often he reported that the drugs were not available at hospital and the church had to give him money to buy from private pharmacies because he got so disturbed if he did not have his drugs.(LDS1)

Further, some of the respondents pointed out that the church has well established structures that support community health activities. For example respondents reported having health departments in their churches, active community linkages through church home groups, as well as close working relationship with the family structure which was regarded as the first level of care and support as noted by one of the respondents

“The best institution to support these people is the family because the problems start in the family”. (LDS2)

“Also responses to mental health problems should look into the family life, the stresses involved and how people interact because violence abuse and trauma in families are common also contributing to poor mental health in the country.(RC1)

In line with the above, one of the clergy for example reported that their church was involved in “...a number of educational programmes aimed at cultivating good relations with the family”,

Another example of community intervention by the church was assisting vulnerable people with both food and non-food items;

“The church also have a welfare department which support people experiencing life challenges....food or health issues, the church support..... so in a way the support given help to prevent stress among people which may cause mental illness”. (LDS1)

4.6 Church responses to mental illness

Although the respondents cited a range of activities the church could undertake to promote community mental health, the data clearly indicate some shortcomings in the current responses to people with mental health problems. Respondents felt that the clergy were inadequately prepared to assist people with mental health problems. For instance, the services being provided which include counselling, confessions, exorcism and deliverance prayers, teaching, problem solving, advice giving and material assistance were reportedly given in isolation and without full comprehension of the underlying mental health problem. One respondent summed it as “*I would say about 80% are not equipped’ to provide mental health support services*”

4.6.1 Prayers

The most common response by the clergy when approached for assistance on mental health problems was offering prayers. The type of prayers offered varied (that is, general support,

healing, deliverance and exorcism rites) depending on the problem at hand as well as church ideology. Almost all the clergy believed that the prayers offered would effectively heal or deliver the individual from any form of mental illness.

“Basically we pray for and with them, that’s our injection and nothing else... we pray with them and they get delivered”. (ZA2)

In some instances clergy’s belief in the power of prayer was so strong that it leads to persistence in offering prayers even if it was not yielding the desired results. This was attributed to lack of knowledge about mental health problems and its treatment. For example, one of the respondents reported how they were inappropriately responding to congregants who had epilepsy;

“During the first days when they had fits in the church, we would quickly rush and do prayers and it was more like a panic response. We would pray deliverance prayers, to cast out the spirit but the person did not respond....this happened for some time but later some relative then told us he had epilepsy and from that point we would not rush into prayers but maybe help him by loosening tight clothes and allow him to rest until he woke up”. (MET2)

A few respondents noted the importance of full understanding of the underlying problem in order to offer prayers that directly relate to the problem:

“Before offering prayers background information is important because you may pray for someone who had not taken his medication or may have taken overdose, so, knowledge of that inform the next course of action, like if the person have taken an overdose he does not need prayers but urgent medical attention”(AFM3)

Some respondents reported offering other services in addition to prayer. However, there was mention of some religious leaders who exclusively rely on prayer as the only treatment for mental illness. For example two respondents expressed concern over church leaders who ascribe all mental illness to spiritual influence and hence offer no other support besides deliverance prayers.

“pastors love to cast out demons and provide spiritual solutions where simple counselling and psychotherapy could have relieved someone of the subjective distress they would be experiencing”.(RC1)

Varied opinions were expressed on the competence of the clergy with regards to spiritual treatment of mental illness. Respondents from the Indigenous Apostolic Churches believed that spiritual healing was a preserve of apostolic churches. Commenting on spiritual healing and deliverance one of the respondents from Indigenous Apostolic Churches pointed out that

*“However, I need to underline that not all churches can do this {healing and deliverance}. Only apostolic churches that are led by the power and wisdom of the Holy Spirit are able to this. The other churches which I may call bible societies do not have the spiritual power to deal with traditional African spiritual issues”.*JM2

It was also reported that church leaders who exclusively rely on prayers for treatment of mental illness often discourage their members from seeking alternative treatment. A number of respondents deplored such beliefs and practises which were regarded as rigid and often cause disillusionment and helplessness among congregants seeking assistance as noted below:

“The problem nowadays is that we have these prophets, chancers who are promising people, giving false hopes on everything..... There is a lot of cheating going on in churches these days and more often these prophets discourage people from using healthcare as they insist and claim that their prayers will answer everything.”(RC2)

Another respondent noted that

“This person was given false hope, that is, was convinced to stop taking her {HIV AIDS} medication and to believe God for a miracle... so her condition and situation started to deteriorate and started to have some kind of confusion, talking to herself and at sometimes could not recognize her children. She got mentally disturbed and at that point the relative took her to hospital and was then treated”(AFM1)

4.6.2 Counselling

The second most common clergy response to people consulting on mental health problems was counselling. It was reported that counselling was usually done shortly before or after prayers as a way of strengthening the individual and or family's coping with the problem at hand. One of the respondents described the object of counselling as,

"to educate the person on how he can either prevent the reoccurrence of the problem or encourage spiritual growth and trust in GOD". (SDA1)

Counselling is also done to other family members so that they do not discriminate people with these problems".(LDS3)

Counselling was regarded an indispensable tool in day to day discharge of clerical duties. Several of the respondents reported frequent involvement in counselling and problem solving with both individuals and families. One of the respondents estimated having three counselling sessions per week. There is evidence from the interviews pointing to the efficacy of counselling being offered by the clergy as illustrated by the three cases below

"I called the young man and had a number of counselling sessions with him. During the session he later disclosed that he was once abused at work by his boss who was gay.....Thank God that he is now picking up"(LDS1)

As with this brother {who had substance related disorder} I had a number of counselling sessions with him.....we also gave him some responsibilities to make sure he will not go into drugs again..... I think it has worked because as I said he is now a changed person, well behaved and doing well in church activities."(LDS3)

".....she came to me and explained what was happening and I realized that maybe she was thinking too much and feeling guilty..... I had a number of times invited her for prayers and counselling. From there the episodes ended. So this only needed counselling, it did not need exorcism or medication from a psychiatric hospital"(MET3)

The clergy was also reported to be giving advice and problem solving support when consulted on issues relating to mental health problems. Worth noting was that these interventions incorporated

other family members thus building family cohesiveness as well as guaranteeing continued family support to the suffering individual

“I also prayed with these people and sometimes discussed their problems with other family members to try to get solution to the person’s problems”(LDS1)

Notwithstanding the above success stories, most of the clergy could not fully explain the counselling approach and techniques used. The diversity of church doctrines and clergy training portray the church as a heterogeneous group employing various counselling approaches to address the congregants’ psychosocial problems. To this end, only a few respondents identified their approaches as either Christian counselling or informal counselling. None of the respondents reported using contemporary secular counselling.

“I also do Christian counselling emphasizing on the fear of GOD. If people are under the law of GOD they will no longer engage in sinful acts which may cause mental illness. We counsel our members to Christian values and principles”(ZA1)

Respondents from theological seminary colleges acknowledge lack of specialization in practical theology such as pastoral counselling and chaplaincy. Further, biomedical input on Christian counselling training was not always available as it depended on the tutor’s invitation of guest medical speakers. To this end, some respondents questioned the efficacy of counselling being done by the clergy.

“Most of our pastors are not equipped so the counselling being done is just giving advice, aah what a good friend can do over a cup of tea, that’s what most people {clergy} call counselling, it’s not really systematic,and without resources for referral, they {clergy} end up tinkering with what they are not qualified to do and this sometimes causes a lot of harm”(RC1)

Another respondent noted:

“....our counselling is based on religious or faith background and in that regard, I can say on issues that need medical background, we do not have the information”(MET2)

Several respondents expressed a concern that the majority of the clergy, about eighty percent (80%) as estimated by one of the respondents, were inadequately prepared to provide mental health support services, despite regular clergy consultation and provision of regular counselling services. One respondent further noted that the clergy were not documenting whatever health related service they provided,

“The church however shares the blame because the counselling and healing sessions they conduct are not being recorded, so they do not have the statistics or records like those kept in hospital to show and prove that they are doing something worth recognition.” (AFM1)

4.6.3 Teaching and Confessions

Behaviour change through biblical teachings and sermons as reported one of the important contributions of the church toward the prevention of mental illness. According to the respondents, the clergy are involved in teachings that aim at changing unhealthy behaviours and lifestyles which either led to or were associated with many life problems including mental illness

“The church also teaches how to live for Christ, a life that will not lead to sinful and sometime harmful practices that will cause these anxieties and other mental problems”(ZCC)

The teachings would also bring conviction to the individual to seek allegiance and protection from God. In this regard, the individual would enjoy peace of mind and security that comes from one's belief in God's love, power and protection

“Unless one completely believes in God, they will never have peace; live in distress and prone to mental illnesses. (RC2)

“....when one becomes a Christian, past life and experiences including illnesses will change. It's like opening a new chapter in one 's life history, when the power of GOD is upon you these spirits will not attack you”. (LDS1)

Further, respondents mainly from the mainline churches reported a belief that confessions and meditation have a therapeutic effect on people with emotional and psychological problems

“In the Catholic Church we have sacramental confessions by which the individual admits the evil in him or had done and forgiveness of sins will bring new start to this individual and also an opportunity to change behaviours and lifestyles that expose the individual to mental distress or fatal life consequences”(RC2)

“I also pray with members on their problems and people also make confessions which are also good psychologically for the relief of any feelings one may have towards himself or other people”(RC4)

4.6.4 Other related interventions

Macro-community and congregational level programmes that have a bearing on mental wellbeing of the congregants and the community at large were also reported. For example one respondent mentioned peace building training they were conducting at their local church for both congregants and other community members.

“We are running nonviolence communication skills training, comprising of effective communication, assertiveness, anger management, peace building and the like. This is offered to couples, youths, and also leaders even those from the community”(RC4)

This finding indicate the church’s potential to roll out own mental health support programmes in their communities

4.7 Presentation and recognition of mental illness

All the respondents reported having had close contact with people suffering from mental illness at some point in their lives. At the time of the study, several respondents reported being either recently or regularly consulted by people requiring help on emotional and psychological issues.

One indigenous apostolic church respondent for example reported that he was running a mental illness treatment camp where people with severe and persistent mental illness would stay and undergo spiritual treatment. Worth noting here is the mutual acceptance and collaborative initiatives between the spiritual healer and formal mental health professionals.

“.....at one point one of the nurses from the local hospital came here and told us to bring some of the mentally ill persons to the hospital for treatment when they were not feeling well. At that time we had more than twenty mentally ill persons whom we were assisting here”(JM2)

Although most of the respondents could not name the specific mental disorders, descriptions of the symptoms suggest the following mental conditions; depression, bipolar, schizophrenia, substance related disorders, post-traumatic stress disorders, mental retardation, and puerperal psychosis. Suicide and other mild mental health problem such as stress, trauma, and anxiety were also mentioned as noted in the following descriptions;

“He reported that he sometimes sees people he once encountered during the liberation war charging toward him..... It was clear that this person was being haunted by what may have happened during the war.”(LDS1)

“... would get violent, break things, and spent the whole night talking and shouting,... started to have some kind of confusion, talking to herself and sometimes could not recognize her children...so when she was brought to the church...her hands were tied because she was violent and refusing to suckle her baby”(AFM1)

“I have also seen some women getting mentally ill after delivering babies...” (JM1)

“I wouldn’t know how to classify them but there are signs of depression....for others they have the gathering tendenciesI’m just remembering one of the patients escaped during the night.....when we found him had huge bag and the sack was full of almost everything including his human waste....”. (ANG2)

Data suggest that respondents often experience challenges in recognising mental illness. These challenges appear, firstly, to be related to the difficulties of differentiating mental illness from

spiritual possession when the person presents with psychotic symptoms, and secondly, lack of visible mental illness markers where the person was not psychotic. For example one of the respondents reported sole reliance on the presence or absence of overt behavioural problems for the recognition of mental illness;

“I think it is easy for those {patients} who are very disturbed, like they are violent or no longer bathing and moving around the streets, for these ones one cannot miss the illness. However other types of mental problems for example one who is stressed or depressed, as pastor you may not be able to quickly pick them unless the person come to you and relate the problem” (AFM2)

When the person presents with psychotic symptoms, respondents still had recognition problems relating to differentiating mental illness from spiritual possession. According to the respondents, the manifestation of mental illness could either resemble spiritual possession or was instigated by spiritual factors. In this regard, respondents found it difficult to delineate naturally occurring mental illness from spiritual possession. One respondent for example pointed out that,

“Here in the church we have big problems of differentiating mental illness and demonic possession that is how these two affect the individual. When one has mental illness some people may regard it as demonic possession because for example in the Bible we have examples of mentally ill people who were demon possessed”. (ANG1)

Without systematic screening tools and basic mental health knowledge and information, the data suggest that the clergy would in most cases adopt a spiritual approach in managing the mental illness.

“Some of these medical conditions are hard for the pastors to tell. Pastors always spiritualize everything, they think people are sick because of spiritual factors...” (MET1)

The data suggest that understanding the full range of mental illness was not an easy task. In fact, one of the respondents’ noted that recognising mental illness was equally difficult for non specialist mental healthcare professional who may not have the relevant training and screening tools

“Basically mental health is much underserved area of health in Zimbabwe, it’s under diagnosed in both primary and secondary health care since there is no screening for mental health The result is that mental illness is either somatised or spiritualized”. (RC1)

Interestingly respondents from the Indigenous Apostolic Churches reported how the Holy Spirit assists in revealing diseases, their causes and treatment. In this regard, they reported not having problems in recognising mental illness,

“ the Holy Spirit will reveal the nature of the problem, when the problem started and how it can be solved...”as well as whether “ ...the person need treatment from either the hospital or church faith healers”(UGFAC1)

Contrary to the above claim, the data indicate that spiritualization could be more common among the Indigenous Apostolic Churches. For example, as the interview with the above clergy progressed, ‘spiritualization’ of mental health problems became more pronounced;

“...some spirits just come as a result of thinking too much on life’s difficulties and might result in the person becoming mentally disturbed”.(JM1)

Further down, when the respondent was describing a child reportedly abusing illicit beer, she said

“.... this {abuse of substances} is another form of spiritual influence which is causing mental illness among children. Children will become very wild, in rags as they would be intoxicated and this will affect his brain and body.”(JM1)

4.8 Factors affecting clergy’s response to community mental health needs

4.8.1 Training

The data clearly indicate that the training curriculum of the clergy in Zimbabwe does not cover mental health issues. According to the respondents, mental health was partially covered in related topics and courses such as psychology, sociology and pastoral care and counselling as shown in the following sentiments from the majority of respondents

“No, that subject is not really focal in theological education. For some reason it seems marginalized, it’s something that people do not talk about....we do not even have the language, so it’s missing in our syllabus”.(MET1)

“No. I’m afraid the church is guilty like other things it is one of the issues that does not really stick out.... We just had fragments of psychology”. (AGN1)

The data further suggest that partial coverage of mental health issues in theological training impacted on the clergy’s response to mental health issues. For example, most of the clergy felt they were inadequately trained to offer mental health support services.

“.... our training is not very much detailed that we can tackle complex mental problems. Think we need extra training on these problems”.(SDA1)

I do not feel that my training was good in that area.....I feel I have very basic training on that formation and some of the problems I will not be able to assist”(RC4)

Respondents from theological seminaries also acknowledged the limitations of clergy training on mental health and other practical theological matters such as pastoral counselling and chaplaincy. This gap was attributed to lack of training resources on those aspects

“...if you look at Zimbabwean curriculum for training pastors, one of the weakness is that there is no specialization....we do not have pastors who specialize in social work, pastoral counselling and even chaplaincy”(MET1)

“There are no materials to educate pastors and the church in general on these conditions. One of the reasons why mental illness is not being taught in theological seminary for example is lack of materials, where do I start because most of the materials are in the medical field.”(AFM4)

“... we do not have chaplaincy training in almost all the theological colleges in the country. That’s an area we need to improve on and maybe having chaplaincy visiting or even residing at mental hospitals”(ZA2)

However a few respondents expressed contention on clergy training maintaining that it was adequate for the clergy to provide basic mental health support services in their community. One respondent said;

“Well for those who undergo full seminary training, I think they somehow have basic understanding and able to handle some mental problems. Pastors are trained to assist people with a wide range of problems including marital disputes, bereavement, and even mental disturbances that require deliverance” (EFZ1)

4.8.2 Lack of mental health information

The study findings show dearth of mental health information and lack of discourse on mental health issues both within the church and the community at large. Further, there is evidence suggesting that the general lack of information among the clergy and the general public was related to the prevailing myths and misconceptions, stigma and discrimination, limited referrals and collaboration with formal mental health system, and the underutilisation of formal mental health services.

“Maybe people generally do not have the information and there are lots of myths and misconceptions so maybe that’s why even some professional are hesitant to discuss such issues which they may not be sure of”(ZCC)

Lack of knowledge on both the available community mental health services and the referral procedures was reported as one of the reasons for limited referral between the church and the formal health system.

No I haven’t made any referral. I’m just realizing we should be doing this.... Its more to do with lack of information, mental problems are rarely talked about, so people do not have the information on how and where to get appropriate services. Maybe these issues should be discussed in radios and televisions so that people know because I’m sure there are many people out there who need the services but do not know where to go” (LDS1)

“I’m not aware of other any organization working with mentally ill people. I think these people are not well represented, for example there is no association such as cancer association to help people with mental illnesses in the country”(LDS3)

Stigma and discrimination was reported to be rampant in both the church and the community. These were attributed to the general lack of knowledge and consistent spot on mental health information. For example one respondent pointed out that

“....there is need to put some of these disorders and concepts in vernacular language so that our people clearly understand them. I have noted that local terms for mental problems are very derogatory and they actually fuel stigma against these people. The people are then ashamed to openly seek help because of such terms ‘anemamhepo, anezvakamugara’ and so forth portrays negative attitudes”(ANG1)

Respondents’ opinions on formal mental health systems and the efficacy of bio medical treatment appear to be largely informed by on anecdotal information. For example, one respondent commenting on the formal health system said

“I do not have much information on how the hospitals work but I heard that mentally ill people are given drugs that physically weaken the body and they will spend much of their time sleeping.and they are supposed to take these drugs for the rest of their lives. In other words they are not being treated but just being physically weakened to control their violent behaviour. I have never seen a person {mentally ill} who got medical treatment and later become normal”(UGFAC1)

4.8.3 Lack of integrative approach to the management of mental illness

Church and formal health system relations were reportedly characterized by mistrust and guardedness. It was reported that the clergy face various challenges in their efforts to give moral and spiritual support to congregants undergoing treatment in the formal health system. For example some respondents reported being refused entry into hospitals to see patients when it was outside the specified public visiting times.

The relationship is not that close and there is not much interaction between the two....In some hospitals we are not allowed to see our congregants outside normal visiting hour. So this creates problems because visiting hours is for everybody and if you need to do counseling with your patient you cannot do it during visiting hours because the ward will be crowded.....’(MET2)

A number of factors were attributed to the inherent mistrust between the church and formal health system which include to lack of discussion forums between the two professions, personal beliefs and attitudes, and in some cases economic reasons

“At the moment there is a lot of suspicious and mistrust between pastors and healthcare professionals because they don’t understand each other. There is need to create discussion forums, platforms where the two can exchange notes and share practical experiences....and come up with a shared strategy on how to collaboratively work together to improve services for people with mental health problems”(RC1)

“....if you carefully look at it, {church–health system conflict) its political economy – everyone struggling to keep his area. So it’s an issue of economic survival, an issue of competition whereby the medical system is competing with the church for control of the thematic issues like healing,we also want to reap profits from them {the community}.... With the current situation in Zimbabwe, anything is possible it’s about bread & butter”. (AFM4)

Worth noting was the observation by two respondents who noted that the current suspicion and poor church-health relations were precipitated and perpetuated by disruptive behaviours by some clergy when they visit patients in the wards. It was noted that some clergy would wilful disregard hospital regulations and disrupt hospital processes.

“.....pastors need to understand that at times hospital processes takes precedence. Also some church leaders, maybe it’s due to lack of training or what, they end up disturbing the whole ward by signing and praying at the top of their voices. That could result in some church leaders to be refused entry”.(EFZ1)

One respondent reported how their contributions were sceptically dismissed as unscientific by health professional

Whenever we want to share spiritual matters with medical personnel, they may say prove it or they will say it is not scientifically proven..... Science cannot prove spiritual matters.
AFM1

However, there were a few clergy who reported enjoying good working relations with the formal health care system. For example one respondent said

“We have good working relationship with the hospitals and the local clinic. We acknowledge that health professionals are well trained to handle these people and besides as I said earlier they are also serving GOD in their work”(ZA1)

4.8.4 Health policies and regulations

The need for a regulatory framework to govern the church’s involvement in health issues was noted. Respondents expressed concern over the increasing malpractices and abuse of clients during the treatment period. For example, commenting on how some churches conduct healing services for the treatment of various ailments, respondents reported that;

“...the living conditions under which this person {mentally ill} is kept during the period of prayers may be very inhuman for example I heard of some apostolic sect that use to tie mentally ill people to trees at their shrine during treatment”(AFM1)

“I have however noticed that in some apostolic churches, people are being deceived for instance some mentally ill people are being given water with mental tablets to control them. When they become calm, they are made to pay for the services on the ploy that they have been healed” (JM1)

To address the above challenges, one respondent recommended the introduction and enforcement of regulations on church’s health related activities as restricting the provision of alternative treatment services to qualified and certified clergy. Suggestions were made for the government to officially recognise and monitor alternative mental health treatment through the certification and registration of the clergy who undergo basic mental health training.

On the other hand some clergy bemoaned the blatant disregard and non-observance of health regulations by health professionals

“I was in the Health Professions Council for eighteen years and the medical ethics relating to these issues {clergy hospital visits}for example, denying patient’s right or wish to see his priest were not given due recognition and observance” (RC3)

Chapter 5 Discussion

5.1 Overview

This study was undertaken in an attempt to understand the processes by which mental health issues are understood and managed by Christian clergymen. The study was undertaken within a biopsychosocial-spiritual model of mental illness, an extension of the traditional biopsychosocial model. The former contends that spiritual beliefs have an influence on thoughts, emotions and actions regardless of religious background (Monteiro, 2015; Cumella, 2002). Qualitative in-depth interviews were conducted to explore the clergy's conceptualization of and response to people who present with or seek assistance for mental health problems. The results of the study highlight spiritual factors as powerful influencers of the perceptions of and management of mental illness by the clergy in Harare, Zimbabwe. The clergy were regularly consulted on a variety of emotional and psychological problems. Assistance was readily provided for these problems by all denominations, and was provided despite professed capacity gaps in the recognition and management of mental illness, and lack of appropriate training in basic mental health issues. The study further revealed a number of church-run health programmes into which mental health support activities could be integrated. Participants recommended mental health education and training as an initial step towards enhancing the clergy's capacity to recognise mental disorders, provide mental health first aid, crisis intervention, and mental health treatment support through early identification, increased referral, and community care. The need for regular dialogue and information sharing with formal health services was regarded as a linchpin for the collaborative management of mental health problems. Below, the results are elaborated in terms of the implications of the clergy's understandings of mental illness, the process by which mental health needs are identified and managed and the perceived role and contribution of church to community mental health.

5.2 Conceptualization of Mental Illness

Overall, while respondents acknowledged biomedical and psychosocial causes, the study revealed a predominance of supernatural explanations for mental illness. This finding attests both

the importance of spiritual beliefs and cultural practices in the life and wellbeing of local people as well as the utility of the extended biopsychosocial-spiritual model in explaining the broader sociocultural and religious nuances of mental illness (Monteiro, 2015; Atilola, 2015; Cumella, 2002).

The current study underlined the predominance of supernatural factors in the understanding of mental illness within spiritually entrenched religious healing systems. The study findings were consistent with previous studies reporting on explanatory models of mental illness in other African communities (Ventevogel et al., 2013; Abbo 2011; Sorsdahl et al., 2010), showing that the clergy uphold indigenous explanatory models, were familiar with mental illness and were actively involved in treatment and care of persons experiencing mental health problems. The clergy's spiritual attributions of mental illness were very much in keeping with the African worldview of disease and health and to a greater extent similar to indigenous African traditional healers' spiritual explanations of mental illness relating to superhuman factors such as alienation from the Supreme God and ancestral gods, spiritual attacks, oppression and possession, magic, bewitchment, and sorcery (Atilola, 2015, Teuton et al., 2007; Teferra & Shibe, 2012; Sorsdahl et al., 2010). Although some researchers may dismiss such worldview as lay and superstitious (Shizha & Charema, 2011), there is evidence showing that one of the main factors promoting high patronage of alternative mental health care practitioners, including the religious and faith healers, is the tendency of such practitioners to give explanations and remedies that are in tandem with the prevailing worldviews of the consulting individual, caregiver and community (Atilola, 2015; Lukachko, Myer, & Hankerson, 2015; Gureje et al., 2015).

Spirituality is defined differently in secular and religious circles. However, it is generally agreed that in both contexts, it involves a deep sense of longing for and/or connection with something beyond the material world (Hefti, 2011; Cumella, 2002; Hill, et al., 2000). In the study, the clergy's conceptualization of spirituality was more inclined to religious notions relating to preoccupation and or connection with transcendence and the mystical realm (Hefti, 2011; Leavey, 2010; Moreira-Almeida et al., 2006). The current findings portray clergy's view of people as spiritual beings over which superior malevolent and benevolent spirits continuously battle to occupy and exert influence on the day to day life of the individual.

Although the clergy's conceptualization of mental illness was in keeping with the biopsychosocial-spiritual model, there were notable differences espoused by the respondents with regards to the centrality of spiritual factors relative to biomedical and psychosocial factors. Respondents from Protestant and Pentecostal churches tended to attribute mental illness to multiple factors including spiritual and biopsychosocial factors. Respondents from Indigenous Apostolic Churches on the other hand tended to express single spiritual explanations for mental illness. Respondents interviewed from the former churches tended to be well educated, while respondents interviewed from the latter churches tended to have low educational levels. Taylor, Chatters & Levin (2004) identify educational level as an important predictor of clergy's mental health concepts, attribution of and response to mental illness. The impact of education on clergy's conceptualisation of mental illness would be an important area for further study in the Zimbabwean context, but is beyond the scope of this study.

Matthews (2007) noted that previous studies indicate that clergy who hold singular spiritual explanations for mental illness, that is, viewing mental illness as exclusively resulting from evil spirits, believe that mental illness can only be treated by their unique spiritual gifts and skills. This view was reported by respondents from the Indigenous Apostolic Churches who believed that spiritual healing for mental illness was done through the power and wisdom of the Holy Spirit exclusively vested in Apostolic churches. Research evidence show that the clergy who subscribe to these beliefs usually discourage any form of bio-psychosocial therapy, as it is viewed as an indication of lack of faith as well as a hindrance to spiritual healing, which is believed to come through faith and prayer. Thus, they would actively dissuade members from seeking formal mental health services (Sullivan et al., 2014; Matthews, 2007).

The respondents' causal attributions and treatment suggestions shed light on the intersections between indigenous traditional and conventional Christian health beliefs in Sub Sahara Africa. Firstly, both the traditional healers and Christian religious leaders' views are subsumed within the broader African concepts of health, disease and illness which are rooted in the spiritual realm (Basure & Taru, 2014; Abbo, 2011; Omonzejele, 2008). Secondly, there is evidence pointing to simultaneous observance of both indigenous traditional and Christian religious practices in the

region (Bourdillon 1987, King 2012). Dual religious consultations were reported as a common practice in the study. The respondents for example noted that some of the congregants were “half-half”, believing in both traditional and Christian practices and would therefore consult either a witchdoctor or a Christian religious healer for assistance on mental health problems. Similarly, King (2012) reported concurrent consultation of Christian religious healers and African tradition healers in rural South Africa

Bourdillon (1987) had earlier commented that although many Zimbabweans claim to be Christians, they continued to believe in the power of witchcraft and of their ancestral spirits without feeling guilty over the incompatibility of traditional and Christian religious belief systems. Thus, both the current study and previous findings seem to suggest that there is a thin line between indigenous traditional and Christian religious beliefs vis-à-vis the significance of spiritual factors in the health and wellbeing of the local people. Although indigenous traditional healers and Christian religious healers may differ in their treatment approaches, their explanatory models and the subsequent health advice (rooted in prevailing social and cultural systems) given to consulting patrons are fundamentally similar in the way they influence community health perceptions, help seeking behavior and care pathways. Thus, both traditional healers and religious and faith healers are important stakeholders worth partnering with in community mental health interventions. Collaborating with traditional medicine practitioners is very much in keeping with the holistic concept of health and the traditional and complementary medicine framework (Gureje et al., 2015; Monteiro, 2015; Abdullahi, 2011)

The clergy’s conceptualisation of mental illness and the points of convergence with both traditional indigenous healers and the prevailing public perceptions of mental illness also merit consideration in community mental health care planning (Lukachko, Myer, & Hankerson, 2015; Gureje et al., 2015; Teuton, Bentall & Dowrick, 2007). Patel (1995, p. 223) wrote “for any mental-health initiative to be successful, it must reach out to the ordinary person and must be sensitive to his or her world-view.” This emic perspective to mental health care argues that prevailing sociocultural factors are fundamental in the planning and designing of care interventions, since mental illness is conceptualised differently across the world. (Atilola, 2015; Shizha & Charema, 2011; Patel, 1995). Research studies show that when biomedical explanations clash with the user’s worldview, the resultant disconnection may dissuade user

from seeking formal mental health care (Monteiro, 2015; Gureje et al., 2015; Atilola, 2015), as was noted with respondents who expressed singular explanations on mental illness earlier in this discussion. According to Gureje et al., (2015), a shared patron-provider consciousness and beliefs about the causes and treatment of mental illness reinforce the patron-provider relationship as well as stimulate a joint effort to end the abnormal experience of illness. In this regard, it is prudent for mental health practitioners and policy makers in low-income countries to tailor-make mental health policies and service that are attuned to the prevailing sociocultural and religious factors. Further, mental health practitioners and policy makers should promote collaborative interventions with complementary traditional medicine practitioners. (Monteiro, 2015; Gureje et al., 2015; WHO, 2002, 2013; Cumella, 2002).

Notwithstanding the predominance of spiritual factors, the clergy also attributed mental illness to a number of causes including biological, psychological, environmental, and social factors which were consistent with both the biopsychosocial-spiritual model and previous studies conducted among the clergy in low- and middle-income countries (Matthew, 2008; 2007; Ally & Laher, 2008; January & Sodi, 2006). In the study, a number bio psychosocial factors which include physical illnesses, brain damage, genetic factors, abuse of substances, trauma, poverty, and marital violence were also noted as causal factors for mental illness. The clergy's multidimensional conception of mental illness is very much in line with conventional models of mental illness and consistent with previous studies in Zimbabwe in which poverty and lack of psychosocial support (Nyamukapa et al., 2010), drugs, unemployment, and marital problems (January & Sodi, 2006), AIDS and chronic physical illnesses (Patel, 1995) were reported as causing mental illnesses. The clergy's conceptualisation of mental illness reflects a positive and encouraging level of mental health literacy which can be nurtured to raise community mental health awareness.

Reviewed studies document positive associations between, spirituality, culture, religiosity and mental health with respect to psychological wellbeing, depression, drug abuse and suicide (Lukachko, 2015; Koenig et al., 2012; Moreira-Almeida, 2006). According to Hodges (2002), the search for meaning and purpose in life is a key component of good mental health. In line with

the above studies, various aspects of spirituality in relation to wellbeing and one's meaning or purpose in life were also expressed by the clergy through such themes as love, belonging, hope, peace of mind, forgiveness, security, and healing. Respondents further perceived the church as well positioned to offer psychosocial support, foster positive wellbeing and numerous opportunities for socio-economic networking and development. The reported positive aspects of spirituality concur with previous research findings on the link between religion, spirituality and mental wellbeing (Lukachko, et al, 2015; Hefti, 2011; Leavey 2008; Koenig, 2008). More importantly, the reported themes echo fundamental principles for mental health recovery through holistic biopsychosocial and spiritual models of care (Lukachko, et al., 2015; Sullivan et al., 2014; Cumella 2002).

5.3 Role and Contribution of the Clergy.

Clinebell (1970, p. 46) once wrote "Churches and temples collectively represent a sleeping giant, a huge potential of barely tapped resources for fostering positive mental health." Similarly, respondents in the study reported opportunities for multidisciplinary collaboration to promote mental health, including concerted efforts to combat stigma and discrimination, raise mental health awareness and provide mental health counselling, care and treatment support. Indeed there is evidence suggesting multiple roles and contributions of the clergy and the church towards the health and wellbeing of their members (Hankerson & Weissman, 2012; Koenig et al., 2012; Taylor, 2000; Weaver, 1995). Sullivan et al. (2014) reported an increase in both research and practice on the integration and collaboration between the clergy and mental health providers in United States of America and the United Kingdom. These include, for example, the establishment of research centers in academic institutions, setting up of church mental health ministries, as well as the employment of pastoral counsellors who use mental health principles and techniques in counselling (Sullivan et al 2014). Further study into the utility of these and other collaborative measures would assist in encouraging collaboration in the Zimbabwean context.

Clergy perspectives on mental illness is not only of benefit at the individual and family level, that is, for congregants who consult them, but are crucial perspectives to embed in an integrated

mainstream health system which is responsive to the needs of the population it serves. The clergy reported their role as not only complementary to formal health care system, but as a missing piece to complete the holistic treatment and care puzzle. Dealing with malevolent spirits and attending to patients' spiritual needs such as restoring hope and fostering meaning in life were reported as the clergy's niche in a comprehensive health care system.

While this finding was consistent with previous reports on pluralistic health care systems in low and middle income countries (Lukachko et al., 2015; Gureje et al., 2015; Adewuya & Makanjuola, 2009; Kar, 2008) the framework for effective collaboration with traditional medicine practitioners remains unclear given the disparate inter and intra religious beliefs and practices. For example, the clergy in the study had no kind words for indigenous traditional healers, while conflicting Christian ideologies and practices were also reported. Ideological differences among and between traditional medicine practitioners have also been reported in local media reports as hindering the implementation and monitoring of traditional and complementary medicine in the country (Religion in Zimbabwe Organisation: 4814, 2012). For example, due to incompatible belief systems, Christian spiritual healers in the country defy provisions of the Traditional Medical Practitioners Act of Zimbabwe (1981) which require them to be registered and licensed in the same category with other indigenous traditional healers involved in practices relating to the diagnosis and treatment of illnesses of the body or mind by traditional methods (Religion in Zimbabwe Organisation: 4814, 2012). Thus, there is need for more research and deliberation on the operational framework for collaborative engagement and interventions involving indigenous beliefs and practises.

Notwithstanding the foregoing observation, the study findings resonate with previously reported clergy and church based responses to community mental health needs (Sullivan et al., 2014; Hankerson & Weissman, 2012; Milstein et al., 2008). Respondents in the study reported that they were regularly consulted and devoted considerable time in helping members presenting with a range of emotional and psychological problems. Counseling, for example, was reported as one of the regular mental health support activities which the clergy was involved in on a weekly basis. Although the adequacy and effectiveness of clergy responses could not be ascertained beyond respondents' subjective opinions, the study finding concurs with previous studies where the

clergy were reported as frontline community mental health workers assisting congregants and the general public on a wide range of mental and psychological problems (Leavey et al., 2012; Wood et al., 2011; Payne, 2009). For instance, Young, Griffith & Williams (2003) reported that African-American pastors in the USA spent more than six hours of counseling work weekly on average and often assisted persons with serious problems similar to those seen by secular mental health professionals. Drawing from the evidence indicating some favorable outcomes on clergy community mental health support programmes in high income countries, Singh et al. (2012) argued that the clergy in low-income countries can also develop capacity on specific community level activities to promote community mental health and reduce both the burden and treatment gap for mental disorders (Lukachko et al., 2015; Wood et al., 2011; Farrell & Goebert, 2008)

Literature on church-based health interventions document positive health outcomes following various church-run health programmes for a number of health conditions including depression, cancer screening, dietary change, smoking cessation and diabetes treatment (Hankerson et al., 2013; Taylor et al., 2000). Further, research on community-based interventions suggest that mental health care could be delivered effectively by trained and supervised lay and non-specialist health workers (Mendenhall et al., 2014; Kakuma, 2011; Chibanda et al., 2011). Respondents in the study expressed firm convictions that if the clergy are sensitized and trained in basic mental health and a referral and management protocol for mental disorders, they could positively impact community mental health through awareness raising, early identification and referral, and the provision of initial and follow-up counseling, treatment and care. However, there is need for further research on specific clergy-based mental health stepped care and task shifting interventions (Mendenhall et al., 2014; Koenig et al., 2012). The available evidence is sparse and of dubious quality to inform development of community-based health interventions which account for the intersection of spirituality, religion and mental health in low- and middle-income countries, and guidelines on the operational framework on collaborative engagement of the clergy to promote community mental health care (Mendenhall et al., 2014; Sullivan et al., 2014; Koenig et al., 2012).

Milstein et al. (2008) noted that the clergy's personal and lifelong relationships with congregants provide a sense of context, support, and continuity before, during, and after treatment. The clergy

were therefore reported as better placed to provide community level monitoring and continuum of care for people recovering from mental illness (Milstein et al., 2008). Respondents perceived multiple roles and noted comparative advantages the clergy and church have, if called upon to assist with mental health issues. For instance, the current study revealed that clergy contact and consultations with mentally ill persons occurred within the context of a longstanding personal relationship, that is, almost all the mentally ill people reported to have sought help from the clergy in the study were current members, former congregants or relatives of congregants. This finding was previously reported as one of the advantages the clergy may have over mental health professionals. Personal relations between the clergy and congregants, their family members and local community members would reduce stigma whilst stimulate love, trust, and empathy necessary for community mental health care and support (Koenig et al., 2012; Wood et al., 2011; Young, Griffith & Williams, 2003). Payne (2009) reported that the clergy maintain personal contact with individuals, families and the community at large and this relationship is continually reinforced by the clergy's involvement in almost every matter relating to an individual's lifespan development, that is, from baby dedication and christening ceremonies, through to marriage and eventual death ceremonies.

Wood et al.,(2011) noted that the clergy often reside in the same community and are consulted on various life issues and at any point by any member of the community thereby removing the stigma and other related barriers associated with consulting formal mental health professionals. Sullivan et al. (2014) reported that increased collaboration between the church and the formal health system reduces community level stigma and discrimination through enhanced user-service provider social contact. Similarly, enhancing public contact and interaction with people living with mental illness has been reported as one of the mechanisms for promoting social inclusion and mental health recovery (Fekadu et al., 2015; Kleintjes et al., 2012). The current findings support the above anti-stigma and discrimination strategies based on enhanced social contacts between the community and mental health users through the latter's inclusion and participation in church programmes and activities. Thus, the clergy and church in general could provide opportunities for positive social contact, recognition, inclusion and participation of people with mental disabilities in mainstream activities (Fekadu et al., 2015; Sullivan et al., 2014; Wood et al., 2011).

Reviewed literature indicate that low- and middle-income countries currently struggle to find the required resources for specialised mental health training hence the continual shortage of mental health professionals (Lund et al., 2015; Monteiro, 2015; WHO, 2014). It is also unlikely that the required number of mental health workers would be realized in the near future without forming alliances for strategic, innovative and cost effective capacity building interventions (Gureje et al., 2015). One potential solution to the above challenge is to partner with churches and faith based organisation to increase the number of non-specialist community mental health cadres through, either, brief clergy training on mental health or the fusion of mental health education in seminary training. The current study noted the clergy's call for basic mental health training as well as curriculum review for theological seminary to incorporate mental health and counselling modules. The author therefore argues that integrating mental health education into seminary training will have a significant multiplier effect on community level professionals. Such professionals will not only be knowledgeable about mental health but will be well positioned to cultivate long term mental health benefits. Such benefits include mental health promotion and education, prevention of mental disorders and provision of mental health counseling, care and support.

Similarly, scaling up mental health care would be a mammoth task if specialist mental health practitioners remain the sole service providers (Gureje et al., 2015). Literature on task shifting suggests a number of approaches, which include the incorporation of non health professionals and lay workers to scale up mental health service delivery (Monteiro, 2015; Mendenhall et al., 2014; Kakuma et al., 2011). Clergy's call for mental health training is very much in line with the global call for task shifting as a strategy for increasing human resources for mental health care. Basic mental health training for task shifting purposes will neither change the clergy into specialist health workers nor add foreign tasks and responsibilities to the clergy, but rather enhance existing pastoral care duties to include the provision of support and care to vulnerable community members such as mentally ill persons.

Thus, brief training in counseling, problem solving therapy and basic mental health, for example, would sharpen and enhance the quality and effectiveness of the clergy's existing counseling and

psychosocial care interventions, which respondents reported were part of their current duties. Such a model of mental health care task shifting is set to increase access to effective and affordable counseling, psychosocial care as well as reduce the mental health treatment gap through early identification and referral for further formal treatment. A recent multi-site qualitative study on the acceptability and feasibility of using non-specialist health workers to deliver mental health care conducted in five low- and middle-income countries reported that “...religious leaders, faith healers, traditional healers, and other lay people, were preferred to non-specialist health workers, such as CHWs, to carry out the tasks of detecting people with mental illness at the community level” (Mendenhall et al., 2014 p. 40).

This study revealed both human and material resources in the church which could be used to improve community mental health services. For example, the clergy reported that among their congregants were professionals from health, education, social services, community development and other private and public service agencies with running community programmes. Findings further revealed a number of material resources such as the availability of church premises as well as structures which continually link the clergy to community members and processes. This is not unusual as Fagan et al. (2012) reported that church-health partnerships in health promotion are being run in many countries. Faith-based communities provide multiple resources which include tangible assets such as physical resources, human resources and communication networks, and intangible assets, such as interest, religious values and social support. In the current study, the noted limitations and inertia with regards to church-based initiatives to promote mental health were reported to be due to lack of mental health knowledge, lack of interface and dialogue with the mental health professions and lack of a coordinated community framework to guide and support church-based mental health initiatives. Thus the government and other mental health stake holders need to work on transformative policies and strategies which can address the above obstacles and pave the way for regulated church-based mental health support initiatives. Research suggests that bidirectional education, training and dialogue on mental health, spirituality and religion hold promise for establishment of a working alliance set to enhance mutual collaboration between the clergy and mental health professionals (Sullivan et al., 2014; Leavey et al., 2012; Weaver et al., 2003).

The study further reveals clergy's involvement in strengthening family and community structures, including building social relation, promoting healthy lifestyles, coping, resilience and timely response to day-to-day life shocks. This is particularly important given that the burden of caring for mentally ill people frequently falls on family members and the communities in which they live (Kleintjes et al., 2013; Hsiao, 2006; Yip, 2003). A recent study on caregivers' burden for mentally ill patients in Zimbabwe for example, reported heavy family care giving responsibilities and limited caregiver support from mental health professionals. The study further reported that 68% of the caregivers were at risk of common mental disorders while 9.7% had suicidal ideation (Marimbe, 2013). Literature on the coping strategies employed by caregivers for mentally ill patients indicate that most women caregivers in low- and middle-income countries use prayer and belonging to a community support group (which in most cases was being a member of a particular church), as a way of coping with the heavy responsibilities of caring for mentally ill people (Lukachko et al., 2015; Marimbe, 2013; Shibre et al., 2003). In view of the above findings, strengthening the clergy's response to community mental health needs will go a long way in providing the much needed psychosocial support for both the patient and the caregiver as well as easing a gender-based care-giving burden.

As elaborated above, the study findings suggest that the clergy are well placed to promote mental health and to increase both the demand and utilization of mental health services given their community reputation, their access to large crowds of people and more importantly, availability of church community structures and resources ideal for health education and information dissemination. The author therefore argues that investing in mental health literacy among the clergy will positively impact the mental health landscape in the country. There are suggestions that improved public knowledge and awareness about mental disorders has tremendous implications for mental health promotion, prevention of mental disorders, demand creation and service utilization and mental health treatment and care (Atilola, 2015; Muga & Jenkins, 2008). Similarly, poor understanding of mental disorders was reported as one of the major barriers to mental health service delivery in sub-Saharan Africa, and recommendations for public mental health education and specifically the psycho-biological basis of mental disorders is well documented (Sorsdahl et al., 2010; Teferra & Shibe, 2012; Hugo et al., 2003). Further, the clergy's occupation and social standing, that is, being a reputable professional whose role is well

perceived and trusted by community members gives them a comparative advantage over other potential community health promoters. Reviewed literature also indicate extensive church and faith based organisation's involvement in health service provision including the running of an estimated 40% of the healthcare infrastructure across sub-Saharan Africa (Widmer et al., 2011) as well as successful implementation of various church-health promotion programmes in high income countries, (Sullivan et al., 2014; Hankerson et al.,; Hankerson & Weissman, 2012)

5.4 Recognition and Management of Mental Illness

Consistent with reviewed literature, most clergy in the current study had no prior mental health education and training and as such, could not confidently assert that they were able to identify and address the mental health needs of their congregants. Previous studies show that although the clergy are extensively patronized (Lukachko et al., 2015), their biomedical understanding of mental illness, recognition of mental disorders and their knowledge of available mental health services and referral processes were limited (Lukachko et al., 2015; Singh et al., 2012; Nguyen, Yamada & Dinh, 2012). For instance, Farrell and Goebert (2008) reported that 71% of clergy surveyed felt inadequately trained to recognize mental illness and Leavey et al., (2012) reported that studies in the USA show that between 50% and 80% of clergy from major religious groupings considered their seminary training in pastoral counseling to be inadequate vis-à-vis the emotional and psychological issues they often have to contend with. The current study similarly indicates a dire need for mental health education to enhance the clergy's ability to correctly recognise, advise, offer initial treatment and refer cases they cannot handle to formal health care providers (Sullivan et al., 2014; Leavey et al., 2012; Farrell & Goebert, 2008).

Liturgical management of mental illness as reported in the current study, is consistent with previous findings which include prayer and ritual healing (Leavey, 2010; Ally & Laher, 2008), counseling and problem solving (Farrell & Goebert, 2008; Matthews, 2007; Young et al., 2003) community care and support (Leavey, 2008), and referral for psychological and medical care (Wood et al., 2011; Stanford & Philpott, 2011) among other approaches. In the study, respondents reported a range of spiritual responses predominated by counseling and the offering of prayers. One respondent, for example, reported conducting an average of three counseling

sessions per week. However, respondents could not articulate the theoretical underpinnings of the reported individual and family counseling, and its effectiveness remains questionable. Most respondents reported practicing ‘informal counseling’, a few reported ‘Christian counseling’ and only two respondents with prior mental health training reported using modern psychological counseling techniques. This finding contrast with recent findings in high-income countries where the clergy were reported as increasingly using contemporary mental health principles and techniques in counselling as well as referring clients to formal mental health professionals for further management (Sullivan, et al., 2014; Wood et al., 2011). Since the use of modern psychological techniques in counselling was reportedly associated with the clergy’s prior mental health related training (Sullivan, et al., 2014; Young et al., 2003), it can be argued the provision of mental health information and education through suggested methods such as brief in-service training, infusion of mental health curriculum into seminary training or specialised post seminary training, might improve the clergy's understanding and use of mental health principles in their day to day psychosocial support and care activities. The health sector could provide expertise for training and supervision.

Interestingly, respondents were able to recognize maternal mental ill health problems. Although the respondents could not specifically name the disorders, descriptions of women “...*getting mentally ill after delivering babies*” suggest the awareness of clinical antenatal and postnatal depression. This finding is important given the prevalence of maternal mental ill-health in low and middle income countries (Fisher et al., 2012) including Zimbabwe. For example, Chibanda et al. (2010) reported a 33% prevalence for postnatal depression among women attending postnatal care at two urban primary care clinics while an earlier study (Stranix-Chibanda, et al., 2005) had reported a 17% psychological morbidity among pregnant women attending an urban primary care clinic in Zimbabwe.

One of the reasons given by respondents in the current study for the poor maternal mental health was the occurrence of domestic violence perpetrated against women in families characterized with entrenched patriarchal values and inequalities. This observation resonates with previous studies on the prevalence and risk factors for postnatal depression in low-income countries. In the WHO’s multi-country surveys on women’s health and domestic violence against women that

had been conducted in ten countries between 2000 and 2003, it was found that 15%–71% of ever-partnered women had suffered physical or sexual violence or both, perpetrated by current or former partners. Similarly, a systematic review of the prevalence and determinants of common prenatal mental disorders in women in low- and middle-income countries reported socioeconomic disadvantages and difficulties in intimate partner relationships as closely associated with increased risk (Fisher et al., 2012). Respondents in the current study noted opportunities in the church for sensitizing the public on maternal mental health and as well as combating gender inequalities and violence against women.

The current study adds to previous findings on the link between poverty and mental disorders (Kleintjes et al., 2013; Lund, et al., 2011; WHO, 2010). In the current study, socio-economic challenges were reported as either causing or exacerbating poor mental health. Previous studies, for example, Lund, et al., (2011) reported the complex and vicious cycle of poverty and mental ill health while other socio-political and environmental factors such as homelessness, migration, war, conflict and disasters have been reported as increasing the vulnerability and burden of mental disorders in Africa (Monteriro 2015; WHO, 2014; Lund et al., 2011). Respondents noted that comprehensive management of mental illness should incorporate strategies for addressing poverty, socio-economic inequalities, violence, stigma and discrimination. This finding concurs with suggested strategies for addressing pervasive stigma and the socio-economic exclusion of person with psychosocial disabilities in mainstream development policies and programmes (Kleintjes et al., 2013). Lund et al. (2011) noted the need for comprehensive approaches and multi-level interventions to address both the social vulnerabilities of mental illness and economic deprivations as both causes and consequences of mental illness.

The reported negative relationship between the clergy and health professionals impacts on clergy management of their congregants, and requires thoughtful action. The results clearly show that the clergy – health professional relationship was largely characterized by hidden conflict, mistrust, discontent and lack of appreciation of the role and contribution of the counterpart profession. This negative working relationship and the subsequent low levels of referral and collaboration between religious leaders and formal mental health professionals featured prominently in studies conducted before the twenty first century in the United States and United

Kingdom (Oppenheimer et al., 2004; Weaver et al., 2003). The current findings, though consistent with historic studies conducted prior to 2000 in the United States and United Kingdom, contrast sharply with recent literature and research in high-income countries which report increased collaboration and appreciation of the intersection of religion and mental health (Sullivan et al., 2014; Leavey et al., 2012). Sullivan et al. (2014) for example report a notable increase in dialogue and partnership in the provision of mental health care in the United States as well as general acceptance and recognition of religion–mental health intersection by practitioners, faith communities, policy makers, patients and general public. Further research on the above paradigm shift will invaluablely inform strategies to influence positive working relationship and increase collaboration between the clergy and formal mental health workers in the study context.

Similarly, Mlambo et al. (2014) reported that the country's mental health care as primarily biomedical and institution- based. In addition, the country was reported to have minimal and poorly resourced occupational and rehabilitation facilities at community level (Mlambo et al., 2014). Just like in other low- and middle-income countries, the limited mental health resources are mainly channeled towards care institutions that are disproportionally concentrated in urban areas (Monteiro, 2015; WHO, 2014). Pursuant to the foregoing observations, the author argues that the availability and accessibility of mental health care at community level could be improved through the recognition and integration of informal support structures such as the church. Once sensitised and equipped with the capacity to assist with mental health issues, these informal community level structures have the potential to be largest community care provider and strongest social support pillar for patients discharged from hospitals, thus bridging the gap between the hospital and community, through a continuum of care model. Kleintjes et al., (2012) noted that informal support facilities are well placed to promote mental health recovery by providing a platform for social connection and fellowship where love, acceptance, and belongingness are nurtured. Thus, the recognition, integration and capacity building of stable informal community structures such as the church, hold promise for addressing some of the unmet mental health needs at community level. As noted earlier, such facilities could be better placed to monitor and support the mental health needs of both the individual and the family given their social and geographical position.

5.5 Recommendations

The current study focuses on the clergy as promoters of wellbeing and supporters of people's need to lead meaningful, satisfactory and productive lives. From the study and the reviewed literature, it is evident that there are excellent opportunities for scaling up mental health care and promoting the recovery of person with mental health problems at the intersection of mental health and religion. A number of recommendations can be drawn from the study pertaining to mental health literacy, research, policy, education and training, collaboration and service delivery.

Mental health literacy

Research evidence suggest that poor understanding of mental health, mental health rights and the available mental health care services ,increases stigma and militates against formal mental health service provision (Atilola, 2015; Teferra & Shibe, 2012; Hugo et al., 2003). The author therefore recommends the development of a national public awareness strategy for the country, which supports mental health outreach and educational campaigns targeting both religious leaders and the congregants to raise awareness on mental illness, mental health rights and the available treatments as well as combating stigma and discrimination against persons with mental illness. As noted in the study, the church is strategically positioned and has ideal community level structures and resources for health education, information dissemination, and excellent opportunities for positive social contact, recognition, inclusion and participation of people with mental health problems in mainstream activities (Fekadu et al., 2015; Sullivan et al., 2014; Kleintjes et al., 2012)

Research

Although literature abounds on the role and contribution of faith communities to mental health, research is needed on implementation models and efficacy of church based mental health programmes (Sullivan et al., 2014; Hankerson & Weissman, 2012 Singh et al. 2012). Local randomized controlled trials and qualitative studies can inform the design and implementation of

both church based mental health support programmes and task shifting approaches involving the clergy.

The study further accentuates the need for studies on the clergy's capacity for and training needs with respect to their response to community mental health needs. The current finding were drawn from a small qualitative sample and little is known on the extent to which theological seminary training prepare their graduates, (either through pre-service training or continuing education), to be better able to recognise, respond, refer and support people with mental health problems.

Supportive policy directives and strategies

There is also a need for mental health policy makers and administrators to formally recognize the clergy and faith based organizations as community level support systems that provide a buffer for individuals and communities against life shocks. Mental health administrators should therefore design policy strategies which create information exchange and initiate networking platforms to build partnerships between themselves, clinicians and faith base organization (FBOs) to support these FBOs to provide comprehensive, long-term community and culturally sensitive mental health services.

There is need to review laws and policies relating to the practice of traditional and complementary medicine in the country. There is a serious discrepancy between the licensing and regulation of health practice for biomedical practitioners and for traditional medicine practitioners. While health care dispensed by biomedical practitioners is licensed and regulated, traditional healing practices often go unchecked as the government appears to have adopted a policy of non-intervention which may expose people with mental health problems to some harmful treatment practices

Collaboration

The study points to the need for more direct contact and information exchange between the clergy and mental health professional to enhance mutual understanding, assistance and collaboration. The formal health system needs information, assistance and contact on spirituality and religious issues while the faith community needs mental health information, assistance and

contacts. The dual information needs could be met through the engagement of chaplains as additional cadres to the community mental health team alongside community nurses and social workers. Chaplains would serve as a link, establishing a point of contact and a channel of communication between hospital and community as well as faith community and health care system.

Further, community mental health workers need to conduct assessments of churches and other religious institution in their service delivery areas to ascertain their operations and the ways in which they either facilitate or hinder access to formal health care services. Such assessments will inform strategies for strengthening collaborative engagements and addressing harmful beliefs and practices.

Training

In view of the reported inadequacy of seminary training on mental health issues against the centrality of mental health knowledge in the daily work of the clergy vis-à-vis psychosocial and physical health issues affecting wellbeing, public mental health should be included as a compulsory course in all theological colleges. It is therefore recommended that a curriculum module on mental health be developed that builds on the intersection of mental health, spirituality and religion.

In Zimbabwe, the government acknowledges the role of the clergy in marriage and family building as evidenced by the state regulated training, certification and registration of the clergy as marriage officers. Mindful of the strategic and symbolic importance of clergy in community mental health, the author recommends a similar training, certification and registration of clergy as community counselors. This would enable the government to monitor the services being provided, whilst ensuring that appropriate, affordable, and effective counseling services are provided to augment primary mental health care.

It would be inappropriate to assume that only the clergy need to learn more about mental health. Mindful of the fact that communities are experts in their own cultural paradigms and have own systems for tackling health problems (Campbell & Burgess, 2012), mental health practitioners

also need to learn and incorporate the spiritual and religious factors in their practice to align biomedicine with cultural concepts of illness and the holistic and client focused bio-psychosocial-spiritual models of care (Monteiro, 2015) Recommendation is therefore made for the review of current psychiatric training and continuing professional development to include spirituality, religion, cultural notions of diseases and indigenous healing practices.

5.6 Limitations of the Study

The study documents the views of twenty eight clergy respondents in Harare on their understanding and response to community members presenting with mental health problems. Notwithstanding the power of qualitative methods to explore and provide thick descriptions of lived experiences of people, the current study has some limitations. Although the data gathered provide valuable background information on the clergy's understanding and responses to mental illnesses in the country, data was drawn from a purposive urban Christian sample. Thus, the study provided a one sided perspective as views of rural clergy and other religious groups in both urban and rural area are missing. Further the heterogeneous nature of the Christian population and the methods used to gather the data limit the generalization of the findings even among the Christian clergy in Harare. This is however an inherent nature of qualitative studies whose aim is not to generalize findings. Therefore, additional research is needed to ascertain the representativeness of the reported attributions and responses to mental illnesses in view of the diversity of Christian beliefs and practices in the country.

Limitations were also noted in the reviewed studies which were primarily descriptive reports and general overviews of church-based programmes and services. The data were important, but evidence from randomized control trials is needed to better understand the feasibility and efficacy of church-based mental health support programmes. Also, large probability samples of service users' experiences and opinions on the clergy mental health support services could provide valuable evaluative data for a broader and balanced conclusion on the use of the clergy as a community mental resource.

5.7 Conclusion

In Zimbabwe, mental health remains a public health concern that is greatly affected by perennial human and material resources. The need for innovative and cost effective interventions to scale up mental health services cannot be over-emphasized. A ray of hope however lies in the pluralistic health delivery system in which the bio-medical system operates alongside indigenous treatment approaches endowed with informal human and environmental resources at community level. The current study therefore explored the predominant beliefs, orientation, practices, resources and capacities of the clergy, as a community level resource, with respect to mental health needs in their communities. Understanding the manner and context in which the clergy have been responding to congregants and community members presenting with mental health problems is an important stepping stone towards assessing both the positive and negative aspects of clergy beliefs and practices as well as strategies for collaborative care approaches anchored in community level human resources. The research study accomplished the set objectives. Overall, the results suggest that providing information and brief training on mental health will not only increase clergy knowledge of mental health issues, but also increase access to appropriate and effective treatment through early identification, increased referral and collaborative care approaches with the formal mental health system.

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APPENDIX A: LIST OF PARTICIPANTS

Code	Sex	Age	Education	Designation	Organization
AFM1	male	45	Dip Theology	Assembly Pastor	Apostolic Faith Mission in Zimbabwe
AMF2	male	39	Dip Theology	Assembly Pastor	Apostolic Faith Mission in Zimbabwe
AFM3	female	62	Dip Theology	Assembly Pastor	Apostolic Faith Mission in Zimbabwe
AFM4	male	43	MSc Peace & Governance	Seminary Lecturer	Apostolic Faith Mission in Zimbabwe
ANG1	male	44	Dip Theology	Assembly Priest	Anglican
ANG2	male	64	BEd	Seminary Lecturer	Anglican
ANG3	male	37	Dip Theology	Assembly Priest	Anglican
EFZ	male	38	Dip Theology	Coordinating Board	Evangelical Fellowship of Zimbabwe
JM1	female	54	Ordinary level Edu	Bishop	Johanne Masowe
JM2	male	37	Ordinary level Edu	Bishop	Johanne Masowe
JM3	male	56	Ordinary level Edu	Bishop	Johanne Masowe
JM	male	62	Bachelor of Arts	Coordinating Board	UDACIZA
LDS1	male		Dip Pension Mgt	Assembly minister	Latter Day Saints
LDS2	male	38	Advance Level Edu	Assembly minister	Latter Day Saints
LDS3	male	36	Advanced Level Edu	Assembly minister	Latter Day Saints
MET1	male	57	PHD Theology	Seminary Lecturer	Methodist
MET2	male	34	Dip Theology	Assembly Pastor	Methodist
MET3	male	55	Master of Arts	Assembly Pastor	Methodist
RC1	male	47	PhD	Coordinating Board	Roman Catholic Bishops Conference
RC2	male	78	PhD	Assembly Priest	Roman Catholic
RC3	male	68	PhD	Assembly Priest	Roman Catholic
RC4	male	51	Master of Arts	Assembly Priest	Roman Catholic
RC CBC	male	57	PhD	Seminary Lecturer	Roman Catholic
SAD1	male	52	Bachelor of Arts	Assembly Pastor	Seventy Day Adventist
UGFAC1	male	42	Ordinary level Edu	Bishop	United Gospel of Faith Apostolic church
ZA1	male	72	Dip Theology	Assembly Pastor	ZAOGA
ZA2	male	48	BEd	Seminary Lecturer	ZAOGA
ZCC1	male	59	Bachelor of Arts	Coordinating Board	Zimbabwe Council of Churches

APPENDIX - B: INTERVIEW SCHEDULE

Section 1: Demographics Data

Can you briefly introduce yourself; tell me how you came to be a clergy?

- age / gender/ education
- current status (assembly, administration, training)
- denomination/ theological orientation
- number of years in the ministry
- number of members in the church congregation
- if specialized training in mental health was received
- any close contact with a mentally ill person or someone experiencing mental health problem

Section 2: Vignettes (Optional, to be asked if response to the last bullet point above is “no”)

Situation 1:

John is a 35 year old man with tertiary level education. During the last month, John has started to drink more than his usual amount of alcohol. In fact, he has noticed that he needs to drink twice as much as he used to get the same effect. Several times, he has tried to cut down, or stop drinking, but he can't. Each time he has tried to cut down, he became very agitated, sweaty, and he couldn't sleep, so he took another drink. His family has complained that he is often hung over, and has become unreliable – making plans one day, and cancelling them the next.

Situation 2:

Mary is a 30 year old woman with high school education. For the past two weeks, Mary has been feeling really down. She wakes up in the morning with a flat heavy feeling that sticks with her all day long. She isn't enjoying things the way she normally would. In fact, nothing gives her pleasure. Even when good things happen, they don't seem to make Mary happy. She pushes on through her days, but it is really hard. The smallest tasks are difficult to accomplish. She finds it hard to concentrate on anything. She feels out of energy and out of steam. And even though Mary feels tired, when night comes she can't go to sleep. Mary feels pretty worthless, and very discouraged. Mary's family has noticed that she hasn't been herself for about the last month and that she has pulled away from them. Mary just doesn't feel like talking.

Situation 3

Maria is a 24 year old woman with a ordinary level education. Up until a year ago, life was pretty okay for Maria. But then, things started to change. She thought that people around her were making disapproving comments, and talking behind her back. Maria was convinced that people were spying on her and that they could hear what she was thinking. Maria lost her drive to participate in her usual work and family activities and retreated to her home, eventually spending most of her day in her room. Maria was hearing voices even though no one else was around. These voices told her what to do and what to think. She has been living this way for six months.

Section C: follow up questions (X representing each of the persons above)

1. In your opinion, what was X experiencing? How did you identify this problem? (*i.e symptomatology, notable changes*). How serious would you consider X problem to be?
2. What do you think gave rise to the problem this person was experiencing? (*i.e traditional beliefs, spiritual / religious model, biomedical, bio psychosocial model, social/ environmental model, other,*) *explore responses*
3. Have you personally assisted members with such condition? *If yes, explore interaction, assistance given, and outcome. If no, ask if X approached you for help with this situation how would you assist?*
4. To what extent do you think your approach has / will have helped the parishioners who seek help from you? Are there barriers to the work you do with these parishioners? Are there any other services you would like to offer? (*Explore*)
5. Given what you have just said, what role, if any, could the church play in supporting parishioners to address these kinds of problems?
6. Are you aware of any other approaches which people may use to address these kinds of problems which you do not personally or organisationally use? (*Explore traditional beliefs, spiritual / religious model, biomedical, bio psychosocial model, social/environmental model, other...explore their views and why not used*)
7. Do you collaborate with any other organisations, services and resources to help your parishioners? How do you collaborate with them? Do they draw on your expertise at all? Do they use the same approach to care as you do? (*Explore*). Has this helped your parishioners? *Explore* Are there any challenges to this collaboration? How have you tried to address these challenges so far? What has helped?
8. Are you aware of any people who may attend health clinics or hospitals to attend to these problems? Do you have any knowledge about how the health services at clinics or hospitals understand these problems? Do you know how they treat and care for people with these problems/ mental illness? What is your view on this (if relevant, *explore suggested role, what being done, challenges*)
9. If formal mental health services are mentioned as a clear option for care by the respondent, *Explore*: Do you have any knowledge about how the health services understand these problems? Do you know how they treat and care of people with these problems/ mental illness? What is your view on this (if relevant, *explore suggested role, what being done, challenges*). *If relevant, further exploration*: Are there already existing emotional and psychological help available to members through your church? *Explore type, length, adequacy of service, training issues*) -Are there any mental health care resources that are available in your community? *Explore what is available in health, education, social services, NGO/ community and other sectors in terms of services, referral and collaboration.*

10. Do you have any other comment/ recommendation to make? Can you suggest other individuals whom you think we may to interview?

APPENDIX C: CONSENT FORM

INFORMED CONSENT FORM

PROJECT TITLE : Conceptualisation of mental illness among Christian clergy in Harare, Zimbabwe.

Principal Investigator : Ignicious Murambidzi

Phone number(s) : +263 772 571 075

Email : murambidzi@gmail.com

What you should know about this research study:

- We give you this consent form so that you may read about the purpose, risks, and benefits of this research study.
- The main goal of research studies is to gain knowledge that may help inform clergy's response to and service provision for people with mental health problems.
- We do not foresee that the research will be of direct benefit to you.
- Should this research make you feel discomfort due to the nature of some of the questions encountered, please feel free to bring this to our attention.
- You have the right to refuse to take part, or agree to take part now and change your mind later.
- Please review this consent form carefully. Ask any questions before you make a decision.
- Your participation is voluntary.

PURPOSE

You are being asked to participate in a research study on the conceptualisation of mental illness among Christian clergy in Harare, Zimbabwe. The purpose of the study is to understand Christian clergy's conceptualisation of and attributions to mental illness and how these factors affect the clergy's perceived ability to respond and provide services when approached by people with mental health problems. You were selected as a possible participant because you are one of the practising Christian clergy in Harare, Zimbabwe, the study's target population.

PROCEDURES AND DURATION

If you decide to participate, you will be asked to share your opinions in an audio taped individual interview. The interview will be conducted in English or Shona depending on your preference. The focus of the interview will be your views, beliefs and experiences with people with mental illness in Zimbabwe. Topics include perceptions of mental illness, causal attributions, recognition of mental illness, and experience with mentally ill persons, and contact with formal mental health services.

During the interview it will be up to you to choose which questions you feel comfortable to answer. The interview should take no longer than an hour and a half, and can be stopped by you at any point, if you do not wish to continue.

RISKS AND DISCOMFORTS

Although the researcher does not think that participation in this project will be harmful, discussions in the interview may make you feel uncomfortable or upset. Should you feel this way, please feel free to bring this to the researcher's attention so that we may discuss and agree on how best to deal with the distress.

BENEFITS AND/OR COMPENSATION

There are no anticipated direct benefits of participating in the interviews for this research

CONFIDENTIALITY

If you indicate your willingness to participate in this study by signing this document, the interview or part thereof may be disclosed to the research supervisor, Dr Sharon Kleintjes from the University of Cape Town, South Africa for the purposes of research supervision and guidance. Otherwise, the interview will be accessible only to the research staff who are bound to protect your confidentiality. Any information obtained during this study which might identify you will remain confidential and will be kept in a secure location accessible to personnel involved in the study only. The reports that will be written about the findings of this study will not identify you in any way. If anything that you say during the interview is written down as a quotation, your name will be changed so that no one will know that you are the person who spoke. The names of other people mentioned in the quotation will also be changed.

ADDITIONAL COSTS

There are no anticipated direct costs of your participation in the study.

VOLUNTARY PARTICIPATION

Participation in this study is voluntary. If you decide not to participate in this study, your decision will not affect your future relations with the University of Cape Town, its personnel, and the associated Alan J. Flisher Centre for Public Mental Health, universities and hospitals. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without penalty.

PARTICIPANT QUESTIONS

Before you sign this form, please ask any questions on any aspect of this study that is unclear to you. You may take as much time as necessary to think it over.

AUTHORIZATION

You are making a decision whether or not to participate in this study. Your signature indicates that you have read and understood the information provided above, have had all your questions answered, and have decided to participate.

I, (Print own name), AGREE to take part in the individual interview for this study focussed on Christian clergy's conceptualization of mental illness.. I know why I have been asked to participate and all of my questions so far have been answered. I agree to this interview being audio taped.

Participant's signature _____ Date _____

_____ Date _____

Signature of Staff Obtaining Consent

YOU WILL BE GIVEN A COPY OF THIS CONSENT FORM TO KEEP.

If you have any questions concerning this study or consent form beyond those answered by the investigator, including questions about the research, your rights as a research participant or research-related injuries; or if you feel that you have been treated unfairly and would like to talk to someone other than a member of the research team, please feel free to contact the following:

- ❖ Medical Research Council of Zimbabwe P O Box CY 573 , Causeway, Harare, Zimbabwe telephone 263 4 791792 or 791193
- ❖ The Chairperson, Research Ethics Committee, Faculty of Health Sciences, University of Cape Town, Private Bag Rondebosch 7700, South Africa Tel. + 27 21 – 406 6338
- ❖ The Research Supervisor, Dr Sharon Kleintjes University of Cape Town, Private Bag X1, Observatory, 7935 Cape Town, South Africa. Tel +27 21 4403 117 ; Email sharon.kleintjes@westerncape.gov.za

Audio, Video Recording and Photography

The interview will be audio recorded. A ninety minutes audio tape will be used. The recorded tape will be disposed after the interview has been transcribed and the information has been compiled into a report

Statement of Consent to be Audio-taped.

I understand that audio recordings will be taken during the study. (Mark either “Yes” or “No”

- I agree to **being audio recorded**

Yes

☐

No

☐

Name of Research Participant (*please print*)

Date

Signature of Participant

Time

Name of Staff Obtaining Consent (*please print*)

Signature

Date

Appendix D subthemes

Summary of representations, domains, themes and

Parent code 1: Dominant beliefs and explanations about mental illness:

Child code 1.1: Causes of mental illness

- Biological
 - Genetic
 - Brain damage
- Religious
 - Sin
 - Demons
- Traditional
 - Avenging spirits
 - Magic /witchcraft
- Familial
 - Marital violence
 - Social upbringing
- Psychological
 - Stressful life
 - Trauma
- Socio-economic
 - Lifestyles
 - Life challenges (poverty)
- Substances
 - Alcohol abuse
 - Drug abuse

Child code 1.2: meaning of mental illness

- Effects /Burden of mental illness
 - Meaningless life
 - Recurring
 - Passive suffering
 - Deterioration
 - Death

Child code 1.3: clergy perception

- natural phenomena
 - natural problems
 - interaction of factors

- pull push factors
- spiritual influence
 - demonic possession
 - spiritual attacks
 - misfortune / magic spell
- Psychosocial
 - Trauma
 - Abuse
 - Guilty feelings
 - Wronged community
 - Life problems
 - Social background

Child code 1.4 information about mental illness

- Availability of information
 - vernacular information
 - rarely talked about
 - use of public media
 - raise awareness
 - lack appropriate language
- Stigma
 - Use of derogatory terms
 - Negative attitudes
 - Labelling
 - Discrimination
 - Misconceptions

Parent code 2 Role and contribution

Child code 2.1: perceived church role

- Role of church
 - Problem solving
 - Outreach / home visits
 - Inclusion
 - Recovery
 - Material support

Child code 2.2 existing church programs

- Support and prevention programmes
- Counselling

- Healing/ deliverance
- Fellowship
- Care and support
- material assistance

Child code 2.2 church capacity

- Church resource
 - Experts in church
 - Congregants initiatives
 - Free services
 - Have time to discuss issues
- Clergy training
 - Inadequate training
 - Short psychology courses
 - Missing in syllabus
 - Curriculum weakness
 - Informal training

Child code 2.3 church limitations

- Human
 - Lack of specialised training
 - Large catchment area
 - Lack experience
 - Individual assistance
- Institutional and Operational
 - lack coordinated services
 - Discourage medical treatment
 - Unsystematic counselling
 - Spiritualisation of mental illness
 - Lack of referral resources

Parent code 3 Identification and management of mental illness

Child code: 3.1 identification of mental illness

- uncertainty in identification
 - lack detection skills
 - difficult separating spiritual and natural illness
 - somatisation in mental illness
 - lack medical knowledge
- Decision making
 - Difficulty initiating help
 - Different belief system

- Service fees
- Physical illness

Child code: 3.2 symptoms of mental illness

- Cognitive
 - Illogical
 - Mixing stories
 - Misinterpret conditions
 - Mental immaturity
- Emotional
 - Mood swings
 - Withdrawn
 - Guilty feelings
 - Uncontrollable
- Behavioural
 - Unkempt
 - Aggressive
 - Loss of self control
 - restless

Child code: 3.3 experiences with mental illness

- Occurrence of mental illness
 - Assisted many people
 - Common illness
 - Huge service demand
- Forms of mental illness
 - Depression
 - Born mentally challenged
 - Suicide
 - Spiritual mental illness

Child code: 3.4 assistance /management

- Church
 - Counselling
 - Healing
 - Confession
 - Prayers
- Family
 - Rituals
 - Concern – encourage treatment
 - Neglect

- Community
 - Awareness raising
 - Tolerance
 - Combat stigma
- Formal health system
 - Medical treatment
 - Professional counselling
 - Physical treatment
 - Personal problem solving

Child code 3.5 intervention outcomes

- Treatment outcomes
 - Permanent healing
 - Temporary relief
 - False hope non selective treatment
 - Cure

Parent Code 4 Pathways to care

Child Code: 4.1 Pathways to care

- Beliefs
 - Freedom of choice
 - Disbelief
 - Spiritual beliefs
- Pluralism
 - Combined treatment
 - Long care pathways
 - Holistic treatment
 - Complementarily
- Alternative treatments
 - Traditional healers
 - Apostolic churches
 - Cultural healing

Child Code: 4.2 Collaboration

- Complementarily
 - Weal church –health link
 - Church recognition
 - Clergy hospital visits
- Information sharing
 - Exchange information
 - Clergy –medical discussion forum

- Combined training
- Ideological conflict
 - Mistrust
 - Spirituality- science debate
 - Coexistence of spiritual and physical illness
 - Source of problem

Child Code: 4.3 Referrals

- Referral system
 - Lack referrals
 - Need two way referral
 - Community referral
 - Never referred

Child Code: 4.4 Perceptions of health services

- Adequacy of services
 - Centralised services
 - Treatment default
 - Lack follow up support
 - shortage of medication
 - Disregard other treatments
- Policies and regulations
 - Practice licence
 - Malpractice
 - Restrictive regulations
 - Grievances

Parent code 5: Recommendations

- Advocacy groups
- Chaplaincy
- Education and training
- Policy review
- Engage policy makers
- Awareness rising
- Church –health collaboration

APPENDIX- E: Approval letters

Introduction and permission request – Church’s governing board

Dear Sir/Madam

Purpose of Study

My name is Ignicious Murambidzi and I’m an MPhil in Public Mental Health student at the University of Cape Town, Alan J. Flisher Centre for Public Mental Health, in South Africa. I am currently conducting a study for my dissertation on the clergy’s conceptualisation of mental illness. The main goal of research studies is to gain knowledge that may add to the body of knowledge on clergy’s attributions and responses when approached for assistance by people experiencing mental health problems.

Background to the study

A number of studies have reported the important role of the clergy as the first and sometimes the only source of help for congregants and community members at large may have when experiencing mental health problems. This study therefore underlines the importance of learning more about the clergy’s understandings and response to mental illness, and to eventually contribute to knowledge on the role and contribution of the church to community mental health.

Procedures

I am writing to ask your permission to conduct the study among the clergymen in your church. The clergy are expected to participant in an interview that will take approximately 60 minutes to 90 minutes. The interview will be tape recorded and the information contained in the tape will be presented in the final report as patterns that emerge from all of the 30 interviews to be conducted. In other words, the author will not report any personal or specific church information that would allow a reader to trace information directly to any particular participant or church as only aggregate responses will be reported.

Participation to the study is voluntary. If your members choose to participate, they are expected to sign a consent and confidentiality form. To ensure the privacy and confidentiality of participants, names and other identifiable information, will not be reported. All research materials will be stored in a locked box and will be destroyed upon completion of this research project.

Risks

At this time there are no harmful effects anticipated from participating in the study. However, in the event that your members feel discomfort due to the nature of some of the questions they have the right to either discontinue the interview session or skip any distressing questions.

Benefits and/or compensation

There are no anticipated direct benefits of participating in the interviews for this research

Participant Questions

If you have any questions or concerns about the study, please do not hesitate to contact me, Ignicious Murambidzi, at +263 772 571 075 or murambidzi@gmail.com. If you have any questions about participating member's rights before, during and after data collection process, please contact the following:

- The Chairperson, Professor Blockman, Human Research Ethics Committee, Faculty of Health Sciences, University of Cape Town, Private Bag Rondebosch 7700, South Africa Tel. + 27 21 – 406 6338*
- The Research Supervisor, Dr Sharon Kleintjes University of Cape Town, Private Bag Rondebosch, 7700 South Africa Tel +27 21 4403 117.*

Researcher Declaration

Beyond publishing or presenting the results from the study, the investigator will not benefit in any other way from your members' participation in this study. Thank you for your consideration and support.

Yours faithfully

Ignicious Murambidzi



Archdiocese Of Harare

Cnr. Fifth Street / Livingstone Avenue
Telephone: 04-764403, 0772 875 947
Email: hrearc@zol.co.zw

23rd January 2014

To Parish Priests



Dear Reverend Fathers,

Re: Mr Ignicious Murambidzi

This letter serves to introduce to you Mr Ignicious Murambidzi, a student at Cape Town University, studying for his M.Phil degree in Public Mental Health.

He has the Archbishop's permission to approach priests with a view to interviewing them as part of his research programme.

I trust you will be able to assist him.

With best wishes,

Yours sincerely,

Signature removed

Fr Brian Enright SJ
Archbishop's Secretary

*The Archbishop's Secretary
P.O. Box CY 330, Causeway
Harare, Zimbabwe
Tel: 764403/07/733/5947*

Telephone: 791792/791193/792747
Telefax: (263) +4 - 790715
E-mail: mrcz@mrcz.org.zw
Website: www.mrcz.org.zw



Medical Research Council of Zimbabwe
Josiah Tongogara / Mazoe Street
P. O. Box CV 573
Causeway
Harare

APPROVAL

Ref: MRCZ/B/593

03 February, 2013

Igcious Murambidzi
Zimbabwe National Association for Mental Health
P. Bag A196
Amondale
Harare
Zimbabwe

RE: Conceptualisation of mental illness among Christian clergy in Harare, Zimbabwe.

Thank you for the above titled proposal that you submitted to the Medical Research Council of Zimbabwe (MRCZ) for review. Please be advised that the Medical Research Council of Zimbabwe has reviewed and approved your application to conduct the above titled study. This is based on the following documents that were submitted to the MRCZ for review.

- a) Research proposal and summary
- b) Informed Consent Form (English)
- c) Questionnaire (English)
- **APPROVAL NUMBER** : MRCZ/B/593
- **APPROVAL DATE** : 03 February 2014
- **TYPE OF MEETING** : Expedited
- **EXPIRATION DATE** : 02 February 2015

This number should be used on all correspondence, consent forms and documents as appropriate.

After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the MRCZ website or our website should be submitted three months before the expiration date for continuing review.

- **SERIOUS ADVERSE EVENT REPORTING:** All serious problems having to do with subject safety must be reported to the Institutional Ethical Review Committee (IERC) as well as the MRCZ within 3 working days using standard forms obtainable from the MRCZ website: www.mrcz.org.zw
- **MODIFICATIONS:** Prior MRCZ and IERC approval using standard forms obtainable from the MRCZ website is required before implementing any changes in the Protocol (including changes in the consent documents).
- **TERMINATION OF STUDY:** On termination of a study, a report has to be submitted to the MRCZ using standard forms obtainable from the MRCZ website.
- **QUESTIONS:** Please contact the MRCZ on Telephone No. (04) 791792, 791193 or by e-mail on mrcz@mrcz.org.zw or mrcz@mrcz.org.zw

Other:

- Please be reminded to send in copies of your final research results for our records as well as for the Health Research Database.
- You are also encouraged to submit electronic copies of your publications in peer-reviewed journals that may emanate from this study.

Yours Faithfully

Signature removed

MRCZ SECRETARY
FOR CHAIRPERSON
MEDICAL RESEARCH COUNCIL OF ZIMBABWE



PROMOTING THE ETHICAL CONDUCT OF HEALTH RESEARCH



UNIVERSITY OF CAPE TOWN

ces



Room E52-24 Old Main Building
Groote Schuur Hospital
Observatory 7925

Telephone [021] 406 6338 • Facsimile [021] 406 6411

Email: shuretta.thomas@uct.ac.za

Website: www.health.uct.ac.za/research/humanethics/forms

20 December 2013

HREC REF: 485/2013

Dr S Kleintjes
Psychiatry & Mental Health
J-Block
GSH

Dear Dr Kleintjes

PROJECT TITLE: CONCEPTUALISATION OF MENTAL ILLNESS AMONG CHRISTIAN CLERGY IN HARARE, ZIMBABWE

Thank you for your letter to the Faculty of Health Sciences Human Research Ethics Committee dated 11th December 2013.

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

We acknowledge that the student, Ignicious Murambidzi is also involved in this study.

Approval is granted for one year until the 30th January 2015

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed the approval period.

(Forms can be found on our website)

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please quote the HREC reference no in all your correspondence.

Yours sincerely

pp Signature removed

PROFESSOR M BLOCKMAN
CHAIRPERSON, FHS HUMAN ETHICS

Federal Wide Assurance Number: FWA00001637.

Institutional Review Board (IRB) number: IRB00001938

This serves to confirm that the University of Cape Town Human Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Convention on Harmonisation Good Clinical Practice (ICH GCP) and Declaration of Helsinki guidelines.